

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card 3. Pages 1 and 2 must be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, for other reasons, the death certificate must be signed by a medical examiner.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 7 7 3  
REG. NO.

|  |  |   |  |  |  |   |  |                                     |  |
|--|--|---|--|--|--|---|--|-------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MIDDLE LAST   |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR  |  | 2b. HOUR                            |  |
| LLOYD  |  | ELEY JR.  |  | 11   |  | 04 84   |  | 3:50 PM                             |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR                     |  |
| Male   |  | Black   |  | 5 MONTH 9 DAY 68 YEAR  |  | 16 YRS.   |  | MONTHS DAYS HOURS MIN.              |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                     |  |
| MD   |  | USA   |  |  |  | BALTIMORE CITY  |  | MD.                                 |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                                     |  |
| BALTIMORE  |  | THE JOHNS HOPKINS HOSPITAL  |  |  |  |   |  |                                     |  |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS / ZIP CODE      |  |
| MD   |  | Baltimore   |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 1502 N. Collington Ave. 21205       |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT                       |  |
| Lloyd  |  | Brenda  |  | No   |  | N/A   |  | Brenda Eley 1502 N. Collington Ave. |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) _____<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  | Cardiopulmonary Arrest<br>Acute Lymphoblastic Leukemia  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5 min<br>1 yr 4 mos  |  |   |  |                                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____   |  |   |  |  |  |   |  |                                     |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                                     |  |
|  |  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |                                     |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |                                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/4/84 to 11/4/84, that (I) (we) lost  |  | 22b. SIGNATURE  |  | DEGREE   |  | 22c. DATE SIGNED  |  |                                     |  |
| saw the deceased alive on 11/4/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.  |  | Faith Hackett   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                          |  | 11/4/84   |  |                                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |  | 22f. DATE REC'D. BY REGISTRAR  |  | 22g. REGISTRAR'S SIGNATURE  |  |                                     |  |
| FAITH HACKETT  |  | JHH-601 N. WOLFE ST BALTO.  |  | NOV 7 1984   |  | Julia Davidson-Randall  |  |                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |                                     |  |
| Burial   |  | 11/8/84   |  | Mt. Auburn Cem.  |  | Baltimore MD  |  |                                     |  |
| 24. FUNERAL DIRECTOR   |  | 24a. NAME   |  | 24b. ADDRESS   |  | 24c. DATE REC'D. BY REGISTRAR                                       |  | 24d. REGISTRAR'S SIGNATURE          |  |
| Wm. C. March F/H   |  | 1101 E. North Ave.  |  |  |  | NOV 7 1984  |  | Julia Davidson-Randall              |  |

2



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

84 29774  
REG. NO.

|   |  |   |  |   |   |
|---|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>SANDRA LYNN ELLMAN</b> <del>XXXXXXXXXX</del>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-24-84</b>  |  | 2b. HOUR<br><b>920A</b>   |   |
| 3. SEX<br><b>F</b> EMALE  | 4. RACE<br><b>C</b> AUCAasian  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 22 51</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>33</b> YRS.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PENNA</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY OF BALTIMORE</b> MD.  |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSP</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>TEACHER</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>EDUCATION</b> |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>BALT</b>  | 13c. CITY OR TOWN<br><b>BALT</b>   | 13d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                       |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ROSS</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>RUTH MAXWELL</b>  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br><b>CHARP</b> ADDRESS<br><b>BURTON L. HIRSCH FUNERAL HOME</b><br><b>2704 MURRAY AVE. PITTS. PENNA</b> |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Widely metastasiz Colon CA</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a   |  |   |  |   |   |
| 19a. DATE OF OPERATION<br><b>Nov 23</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                  |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)       |  |   |   |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>11 00 11 84</b>   |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 23</b> 19 <b>84</b> to <b>Nov 24</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>Nov 24</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.                  |  |   |  |   |   |
| 22b. SIGNATURE<br><b>Steven J. Garon MD</b>   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>11-24-84</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>STEVEN J. GARON</b>   |  | 22e. ADDRESS<br><b>SINAI HOSPITAL</b>   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL / REMOVAL</b>   |  | 23b. DATE<br><b>11-25-84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WESTVIEW CEM</b>   |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ROSS TOWNSHIP. PENNA.</b>  |  | 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS.</b><br><b>6010 REISTERSTOWN RD. BALTIMORE, MD. (21215)</b>                                      |  |   |   |
| 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 28 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |   |   |

MEDICAL CERTIFICATION

29

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |         |  |  |  |  |  |  |   |  |
|---|---------|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |         | 2. DATE OF DEATH   |  |  |  | 3. HOUR  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |         | 20. DATE OF DEATH  |  |  |  | 21. HOUR   |  |   |  |
| Paul Edward Emberger  |         | Nov. 1, 1984   |  |  |  | M  |  |   |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS                           |  |
| Male  | White   | July 15, 1923  |  | 61   |  | MONTHS   |  | DAYS                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |   |  |
| New Jersey  |         | U.S.A.   |  |  |  | Baltimore City MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY         |  |
| Baltimore   |         | Sinai Hospital   |  |  |  | Manager  |  | Social Security                           |  |
| 13a. STATE  |         | 13b. CITY OR TOWN  |  | 13c. INSIDE CITY LIMITS?   |  | 13d. STREET ADDRESS / ZIP CODE                                 |  | 21117                                     |  |
| Md.   |         | Balto.   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 21 H Matinee Court   |  |   |  |
| 14. FATHER'S NAME   |         | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.                                       |  | 17. INFORMANT                             |  |
| Ferdinand   |         | Pauline  |  | Yes  |  | 183-16-3595  |  | 21 H Matinee Court                        |  |
|   |         |  |  |  |  |  |  | Virginia Emberger Owings Mills, Md. 21117 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         |  |  |  |  |  |  |   |  |
| PART 1. DEATH WAS CAUSED BY:  |         |  |  |  |  |  |  |   |  |
| IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>   |         |  |  |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Disease</u>  |         |  |  |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>YLS-</u>  |         |  |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>0</u>   |         |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |   |  |
|   |         |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |         | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |
|   |         | HOUR A.M. MONTH DAY YEAR   |  |  |  |  |  |   |  |
|   |         | P.M. 19  |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED  |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION  |  |  |  |   |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>   |         |  |  | STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| AT WORK AT WORK   |         |  |  |  |  |  |  |   |  |
| 22a. I certify that (this hospital) attended the deceased from <u>12</u> <u>10/29/84</u> to <u>11</u> <u>11/2/84</u> , that (I) (we) lost saw the deceased alive on <u>10/29/84</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |         |  |  |  |  |  |  |   |  |
| 22b. SIGNATURE  |         | 22c. DATE SIGNED   |  | 22d. ADDRESS   |  |  |  |   |  |
| <u>Kenneth M. Zontes</u>  |         | <u>11/2/84</u>   |  | <u>10807 FARNS RD LUTHERACCE</u>   |  |  |  |   |  |
| 22d. SIGNATURE  |         | 22e. ADDRESS   |  | 22f. DATE SIGNED   |  |  |  |   |  |
| <u>Kenneth M. Zontes</u>  |         | <u>10807 FARNS RD LUTHERACCE</u>   |  | <u>NOV 5 1984</u>  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION  |  |   |  |
| Burial  |         | Nov. 5, 1984   |  | Garrison Forest  |  | City or Town County State                                      |  |   |  |
|   |         |  |  |  |  | Balto., Md.  |  |   |  |
| 24. FUNERAL DIRECTOR  |         |  |  |  |  |  |  |   |  |
| <u>H. J. Eckhardt</u> Owings Mills, Md.   |         |  |  |  |  |  |  |   |  |

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 8 4 2 9 7 7 7  |  | REG. NO.  |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>BERNETTA ENNELS  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11-23-84   |  |   |  | 2b. HOUR<br>3:00 P.M.  |  |
| 3. SEX<br>F   |  | 4. RACE<br>B   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>June 22, 1988   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE<br>(COUNTRY)<br>md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Provident Hosp. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>md.   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Balto.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>1109 N. Gay St. 21213   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>unk   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Delia WARD   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO  |  |  |  | 16b. SOCIAL SECURITY NO.<br>unk.  |  | 17. INFORMANT<br>ADDRESS<br>Sherman ENNELS 1109 N. Gay St.                                      |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) STAPHYLOCOCCUS AUREUS SEPTICEMIA<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) PNEUMONITIS, D-I-C<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br>CHRONIC RENAL FAILURE; URINARY TRACT INFECTION  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov-9 1984 to Nov 23 1984, that (I) (we) last saw the deceased alive on Nov 23 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>C. C. ONEJEME   |  |  |  | DEGREE<br>MD  |  |   |  | 22c. DATE SIGNED<br>11-23-84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>C. C. ONEJEME  |  |  |  | 22e. ADDRESS<br>PROVIDENT HOSPITAL  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>11-28-84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Peters. U.M.C.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Dorchester County, Md.                            |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. J. SPICER 1654 N. Broad   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 27 1984  |  | 25b. REGISTRAR'S SIGNATURE<br>Davidson  |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove the certificate from the papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 7 7 8  
REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ISABEL EPSTEIN</b>   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>NOVEMBER 22, 1984</b> |   |  | 2b. HOUR<br><b>1:16 P</b>   |  |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>JULY 9, 1925</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PENNSYLVANIA</b>                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>NURSE</b>                |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>MEDICINE</b>             |  |
| USUAL RESIDENCE (IF IN HOSPITAL, NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |  |  |   |  |   |  |  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTO.</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>7405 BROMPTON RD. 21207</b> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>PHILLIP DRESNICK</b>                                       |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>SYLVIA OSTROFF</b>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                    |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>206-14-2767</b>  |  | 17. INFORMANT <b>MISS ALICE EPSTEIN</b><br><b>6001 SHEAFF LA. FT. WASHINGTON, PA 19034</b>  |  |   |  |  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cardio-respiratory failure**

DUE TO, OR AS A CONSEQUENCE OF

(b) **Widespread Carcinoma**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH  
**15 minutes**

**10 days**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a  
**Coagulopathy**

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION<br><b>11/14/84</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Mass in Colon</b>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>November 1st 1984</b> to <b>November 22 1984</b> , that (I) (we) lost<br>saw the deceased alive on <b>November 22 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Peter Loeb MD</b>   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  |  | 22c. DATE SIGNED<br><b>11/22/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PETER LOEB MD</b>  |  |   |  | 22e. ADDRESS<br><b>550 North Broadway #1105</b>                                      |  |   |  |

|  |  |                                   |  |   |  |  |  |
|--|--|-----------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b> |  | 23b. DATE<br><b>NOV. 23, 1984</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HEBREW YOUNG MEN</b> |  | 23d. LOCATION<br><b>BALTIMORE</b> COUNTY <b>MARYLAND</b> |  |
|--|--|-----------------------------------|--|---|--|--|--|

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 24. FUNERAL DIRECTOR<br><b>Levinson &amp; Bros 6010 Reisterstown</b> |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 28 1984</b> |  | 25b. REGISTRAR'S SIGNATURE<br><b>Jana Davidson-Randall</b> |  |
|--|--|---|--|--|--|



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

## MEDICAL CERTIFICATION

| FOR STATE REGISTRAR  |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 4 2 9 7 7 9   |  |  |  |
|--|--|--|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  | 2a. DATE OF DEATH  |  |  |  | 2b. HOUR  |  |  |  |
| SOLOMON A. ERDMAN  |  |  |  | NOV. 26 1984   |  |  |  | 3:40 PM   |  |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS  |  |
| MALE   |  | CAUCASIAN  |  | AUG. 7 1895  |  | 89 YRS.  |  | MONTHS  |  | DAYS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |  |  |
| RUSSIA   |  | USA  |  |  |  | BALTIMORE CITY MD.   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |
| BALTIMORE  |  | LEVINAVE HEBREW GERIATRIC CENTER + HOSPITAL  |  |  |  | MERCHANT   |  | RETAIL  |  |  |  |
| 13a. STATE   |  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS + ZIP CODE                                 |  |
| MARYLAND   |  |  |  |  |  | BALTIMORE  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 1101 ST. PAUL ST. APT. 1802<br>21202                           |  |
| 14. FATHER'S NAME  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |   |  |  |  |
| AARON ERDMAN   |  |  |  | REBECCA WOLINSKY   |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  |   |  |  |  |
| NO   |  |  |  |  |  | MRS. BEATRICE DICKMAN - 2nd FL.<br>1203 N. CHARLES ST. BALTO., MD 21201        |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (a) RECURRENT ASPIRATION PNEUMONIA   |  |  |  |  |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |  |  |  |  |  |  |   |  |  |  |
| (b) CEREBROVASCULAR ACCIDENT   |  |  |  |  |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |   |  |  |  |
| (c)  |  |  |  |  |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |  |  |  |
|  |  |  |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |   |  |  |  |
|  |  |  |  | P.M. 19  |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED   |  |  |  | 21e. PLACE OF INJURY   |  | 21f. LOCATION  |  |   |  |  |  |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from 10/17, 1984 to 11/26, 1984, that (we) last saw the deceased alive on 11/26, 1984, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did not) view the body after death. |  |  |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE   |  |  |  | DEGREE   |  |  |  | 22c. DATE SIGNED  |  |  |  |
| [Signature]  |  |  |  | MD. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>           |  |  |  | 11/26/84  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS   |  |  |  |   |  |  |  |
| ESTRELLITA O. KIM, MD  |  |  |  | LEVINAVE HEBREW GERIATRIC CENTER + Hospital 21202  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  |  |  |
| BURIAL   |  |  |  | NOV. 28, 1984  |  | WORKMEN CIRCLE   |  | BALTIMORE COUNTY MARYLAND   |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |
| SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD. BALTO., MD 21215   |  |  |  |  |  | DEC 3 1984   |  | [Signature]   |  |  |  |

✕

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3a should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

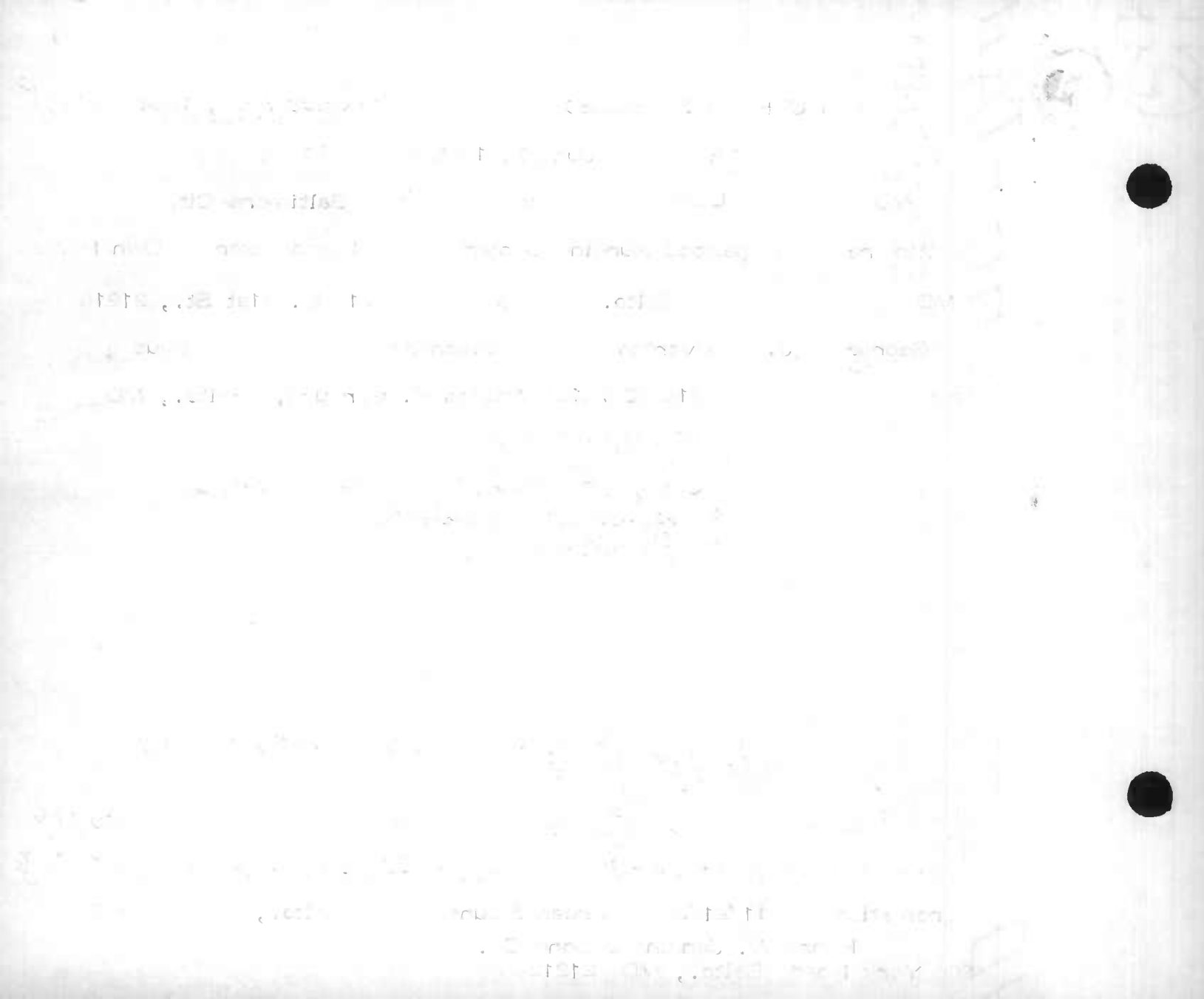
87 29780

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>RUTH G. ESSEX   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 20, 1984 |   |  | 2b. HOUR<br>1:00 P.M.  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>June 7, 1893  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>91 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Edgewood Nursing Center |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home   |  |  |  |   |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   |  |  |  |
| 13a. STATE<br>MD  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Balto.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 13e. STREET ADDRESS / ZIP CODE<br>712 E. 41st St., 21218  |  |  |  |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George J. Overton   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Eleanora Byus  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>216 05 7418   |  | 17. INFORMANT ADDRESS<br>Walden K. Gorsuch, Balto., MD  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ASCVD - CHF</u><br>DUE TO (b) <u>Car 1st Breast E local metast</u><br>DUE TO (c) <u>3 pharyngeal abscesses</u><br>underlying cause lost<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>4. Pharyngitis</u> |  |  |  |   |  |  |  |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WOUND <input type="checkbox"/> NOT WOUND <input type="checkbox"/><br>AT HOME <input type="checkbox"/> NOT AT HOME <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July 10/19/84</u> to <u>NOV 11 1984</u> that (I) (we) saw the deceased alive on <u>10/19/84</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Donald W. Mintzer</u> M.D.<br>22c. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DONALD W. MINTZER   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22d. DATE SIGNED<br>11/20/84   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation   |  |  |  | 23b. DATE<br>11/21/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Mount  |  |
| 23d. LOCATION<br>BALTO., MD   |  |  |  | 23e. COUNTY<br>MD   |  | 23f. STATE   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., MD 21212  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 23 1984  |  | 25b. REGISTRAR'S SIGNATURE<br><u>John Davidson-Randall</u>   |  |

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-copiers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8 4 2 9 7 8 1   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1 - STATE REGISTRAR  |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Reginald E. Eubanks</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH <b>November</b> DAY <b>9</b> YEAR <b>1984</b>  |  | 2b. HOUR<br><b>M</b>   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>8</b> DAY <b>21</b> YEAR <b>1943</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>41</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>621 Radnor Avenue</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13e. STREET ADDRESS<br><b>2344 Lauretta Ave</b>  |  |
| 14. FATHER'S NAME<br>FIRST <b>Reginald</b> MIDDLE <b>E.</b> LAST <b>Eubanks</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Annie</b> MIDDLE <b>Purnell</b> LAST <b>Purnell</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>214-40-2362</b>  |  | 17. INFORMANT<br><b>Reginald Eubanks</b> ADDRESS<br><b>621 Radnor Avenue</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Hemorrhagic brain metastases</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Large cell undifferentiated adenocarcinoma of lung</b>           |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>approx 1/2 hr.</b><br><b>2 months</b><br><b>6 months</b>                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Cigarette smoking</b>   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 13 - 19 84</b> to <b>November 2, 19 84</b> , that (I) (we) lost saw the deceased alive on <b>November 2, 19 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Micheline McCarthy</b> MD   |  |   |  | 22c. DATE SIGNED<br><b>November 9, 1984</b>   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Micheline McCarthy</b>   |  |
| 22e. ADDRESS<br><b>Osler 4 / Johns Hopkins Hosp / Balt. MD. 21205</b>  |  |   |  | 22f. ADDRESS  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11/16/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md Nat Mem Park</b>  |  | 23d. LOCATION<br>CITY OR TOWN <b>Laurel</b> COUNTY <b>Md</b> STATE <b>Md</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Wm. C. March F/H</b> ADDRESS <b>1101 E. North Ave.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 13 1984</b>   |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>John Smith</b>  |  |   |  | 25c. REGISTRAR'S SIGNATURE  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND  |  |  |  |   |   |   |  |  |   |                   |
|--|--|--|--|---|---|---|--|--|---|-------------------|
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |   |   |  |  |   |                   |
| CERTIFICATE OF DEATH   |  |  |  |   |   |   |  |  |   |                   |
| REG. NO. 8 4 2 9 7 8 2   |  |  |  |   |   |   |  |  |   |                   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Hester Louisa Evans   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 15, 1984  |   |  |  |   | 2b. HOUR<br>9:40a |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 21, 1914   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS                                     |  | 7. UNDER 1 YEAR<br>MONTHS DAYS<br>HOURS MIN.   |   |                   |
| 8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 8b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 10. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                    |  |  |   |                   |
| 11. CITY OR TOWN OF DEATH<br>Baltimore   |  | 12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>6505 Laurelton Ave. |  |   |   | 13a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker |  | 13b. KIND OF BUSINESS OR INDUSTRY<br>Own Home  |   |                   |
| 14a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>14a. STATE<br>Maryland   |  |  |  |   | 14b. COUNTY   |   | 14c. CITY OR TOWN<br>Baltimore   |  | 14d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                   |
| 15. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Carl LaMotte   |  |  |  |   | 16. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Cecelia Miller   |   |  |  |   |                   |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR CREDITS)<br>No  |  |  |  |   | 17b. SOCIAL SECURITY NO.<br>217-01-1988B  |   | 17. INFORMANT<br>ADDRESS<br>21214<br>Richard T. Evans, 6505 Laurelton Ave.     |  |   |                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cancer of Colon</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>10 yrs</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>10 yrs</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>10 yrs</u><br>PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) |  |  |  |   |   |   |  |  |   |                   |
| 19a. DATE OF OPERATION   |  |  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |                   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |   |   |   |  |  |   |                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |                   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>  |  |  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |                   |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov 14 1984 to Nov 15 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.  |  |  |  |   |   |   |  |  |   |                   |
| 22b. SIGNATURE<br>William G. Helfrich, M.D.  |  |  |  |   | 22c. DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  | 22d. DATE SIGNED<br>Nov. 16, 1984  |   |                   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |  |  |   | 23b. DATE<br>Nov. 17, 1984  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland Mem. Pk.                        |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Parkville, Balto., Md.                            |                   |
| 24. FUNERAL DIRECTOR<br>ROBERT C. ALTENBURG FUNERAL HOME, INC.<br>6009 Harford Rd., Balto., Md. 21214  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 16 1984  |   | 25b. REGISTRAR'S SIGNATURE<br>L. Davidson                                      |  |   |                   |

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3

November 13, 1962  
Albany, N.Y.  
Dear Mr. [illegible]

Enclosed for you are two copies of a letterhead memorandum dated and captioned as above. The letterhead memorandum is being furnished to you for your information and for your use in the event you are requested to provide information regarding the same.

Very truly yours,  
[illegible]  
Special Agent in Charge

Nov. 17, 1962  
[illegible]  
[illegible]  
[illegible]

Item #1 G597 11/14/84 CW

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 7 8 3

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |   |  |  |
|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Joe (Joseph) L. Evans  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 05 84   |  | 2b. HOUR<br>6 09 PM                        |
| 3. SEX<br>male  | 4. RACE<br>black.  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 29 37   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>47 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N.C.   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD. |   |  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Sinai Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY          |

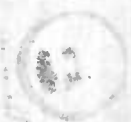
|  |  |  |   |  |
|--|--|--|---|--|
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD |  | 13b. COUNTY<br>Baltimore                                       | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>5946 Green Meadow Pkwy. 21209 |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Herbert Evans  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Willie        |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes                                      | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>239-54-9797 | 17. INFORMANT ADDRESS<br>Greta G. Evans 5946 Green Meadow Pkwy |   |  |

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) ASCVD ? MI, ARRYTHMIA |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last                        |  |   |
| (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |   |

|  |  |
|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>HYPERTENSION |  |
|--|--|

|   |  |  |   |
|---|--|--|---|
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (1) this hospital attended the deceased from 11-5-84 to 11-5-84, that (11) (we) last saw the deceased alive on 11-5-84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we said I did not) view the body after death. |  |  |   |
| 22b. SIGNATURE<br>Patricia A. Snello M.D.   |  | DEGREE<br>M.D.   | 22c. DATE SIGNED<br>11-6-84   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>PATRICIA A. SNELLO   |  | 22e. ADDRESS<br>SINAI HOSPITAL   |   |

|   |                       |  |   |
|---|-----------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial              | 23b. DATE<br>11/13/84 | 23c. NAME OF CEMETERY OR CREMATORY<br>Garrison Forest VA | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Owings Mills MD |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H 1101 E. North Ave. |                       | 25a. DATE REC'D. BY REGISTRAR<br>NOV 7 1984              | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson Randall          |



PALESTINE

2000 COLT



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 4 2 9 7 8 4

FOR  
STATE  
REGISTRAR

|   |  |   |  |   |  |  |   |   |  |  |
|---|--|---|--|---|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>RICHARD THOMAS EVANS</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 27, 1984</b>        |   |  | 2b. HOUR<br><b>5:15a</b>   |   |   |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 6, 1902</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b>   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b>   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>6505 Laurelton Ave.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Electrician</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Self</b>  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  |   | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frank E. Evans</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Edith Hachtel</b>  |   |  | 16. STREET ADDRESS<br><b>6505 Laurelton Ave. 21214</b>   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |   | 16b. SOCIAL SECURITY NO.<br><b>217-01-1988</b>                         |   | 17. INFORMANT<br>ADDRESS<br><b>Gertrude L. Kruelle, 19 Acorn Cir. 21204</b>    |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cancer of Prostate</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>2. yrs</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>2. yrs</b>                |  |   |  |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>2. yrs</b>  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>Nov 27 84</b>          |  |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 27 84</b> 1977, to <b>Nov 27 84</b> 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) examine the body after death. |  |   |  |   |  |  |   |   |  |  |
| 22b. SIGNATURE<br><b>William G. Helfrich</b>  |  |   | DEGREE<br><b>M.D.</b>  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>Nov. 27, 1984</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>William G. Helfrich, M.D.</b>   |  |   | 22e. ADDRESS<br><b>5006 Roland Ave.</b>                                |   |  |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>Nov. 29, 1984</b>                                      |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Mem. Pk.</b>                 |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Parkville, Balto., Md.</b>                                   |   |  |  |
| 24a. FUNERAL DIRECTOR<br>NAME<br><b>ROBERT C. ALTENBURG FUNERAL HOME, INC.</b>  |  |   |  |   | 24b. ADDRESS<br><b>6009 Harford Rd., Balto., Md. 21214</b>                     |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 28 1984</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b> |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





*[Faint, illegible text and markings are visible throughout the page, possibly bleed-through from the reverse side.]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

84 29785  
REG. NO.

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | 2a. DATE OF DEATH  |  | 2b. HOUR   |  |
|   |  | FIRST MIDDLE LAST<br>MARGARET C. EVERHART   |  | MONTH DAY YEAR<br>11/7/84  |  | 9:00 P.M.  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>CAUCASIAN  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 05 25   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>59 YRS.   |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>              |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SOUTH BALTIMORE GENERAL HOSPITAL |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Domestic  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Anne Arundel   |  | 13c. CITY OR TOWN<br>Clen Burn   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 13e. STREET ADDRESS / ZIP CODE<br>1018 Shadwin Drive  |  | 13f. CITY OR TOWN<br>Baltimore  |  | 13g. STATE<br>Maryland   |  | 13h. ZIP CODE<br>21061   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George A. Klein   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Nellie M. Farrell  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO None   |  | 16b. SOCIAL SECURITY NO.<br>21602527   |  |
| 17. INFORMANT<br>Robert B. Everhart III   |  | 17. ADDRESS<br>SAME AS #13  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Metastatic Small Cell Carcinoma of lung |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>11 months  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  | (b)   |  | DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |
| (c)   |  |   |  | DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>Dehydration  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/7/84 to 11/7/84, that (I) (we) lost saw the deceased alive on 11/7/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>Michael E. Klupns   |  | DEGREE<br>MD  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                               |  | 22c. DATE SIGNED<br>11/7/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Michael E. KLUPNS, M.D.  |  | 22e. ADDRESS<br>51364 BALTIMORE, MD 21230   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>11-13-84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Mem Pk.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Clen Burn A-A MD   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>McCully Funeral Home  |  | ADDRESS<br>Balt. MD. 21225  |  | DATE REC'D. BY REGISTRAR<br>NOV 14 1984  |  | REGISTRAR'S SIGNATURE<br>Julia Davidson-Randell  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, death is due to injury, or other traumatic event, the medical examiner must be notified promptly.



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 29786

|  |         |   |                   |  |                  |
|--|---------|---|-------------------|--|------------------|
| 1. FOR STATE REGISTRAR   |         | 2a. DATE KNOWN OF DEATH   |                   | 2b. HOUR   |                  |
| 1. DECEASED NAME (TYPE OR PRINT)   |         | 2c. DATE ESTIMATED  |                   | 2d. HOUR   |                  |
| FIRST MIDDLE LAST<br>Marie Irene Eyer  |         | 11/29/84  |                   | 5:40   |                  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH  | 6. AGE (IN YEARS) | IF UNDER 1 YR.   | IF UNDER 24 HRS. |
| Female   | White   | March 2, 1895   | 89                |  |                  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?  |                   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                  |
| Maryland   |         | U.S.A.  |                   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                  |
| 11. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION  |                   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |                  |
| Baltimore  |         | Johns Hopkins Hospital  |                   | Seamstress   |                  |
| 13a. STATE   |         | 13b. COUNTY   |                   | 13c. CITY OR TOWN  |                  |
| Maryland   |         |   |                   | Baltimore  |                  |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME  |                   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |                  |
| FIRST MIDDLE LAST<br>Herbert Eyer  |         | FIRST MIDDLE LAST<br>Lottie Heffner   |                   | 16b. SOCIAL SECURITY NO.<br>220-22-9289A   |                  |
| 17. INFORMANT  |         | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |                  |
| 6049 Taneytown pike  |         | PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Complications of decubitus ulcers</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |                   |  |                  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |         |   |                   |  |                  |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                   | 20. AUTOPSY?   |                  |
|  |         |   |                   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  |                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |                  |
|  |         | P.M. 19   |                   |  |                  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |                   | 21f. LOCATION  |                  |
|  |         |   |                   | CITY OR TOWN COUNTY STATE  |                  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |   |                   |  |                  |
| ACTUAL SIGNATURE   |         | TITLE (SPECIFY)   |                   | DATE SIGNED  |                  |
| EXAMINER'S NAME (TYPE OR PRINT)  |         | M.D. Assistant MEDICAL EXAMINER   |                   | 11/30/84   |                  |
| Gregory R. Kauffman, M.D.  |         | ADDRESS   |                   | 111 Penn St.   |                  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         | 23b. DATE   |                   | 23c. NAME OF CEMETERY OR CREMATORY   |                  |
| Burial   |         | Dec 3, 1984   |                   | Trinity Lutheran Cem.  |                  |
| 24. FUNERAL DIRECTOR NAME  |         | 25a. DATE REC'D. BY REGISTRAR   |                   | 25b. REGISTRAR'S SIGNATURE   |                  |
| Skiles Funeral Home  |         | 07/11/84  |                   | Julia Davidson-Rodriguez   |                  |
| ADDRESS  |         | 25c. REGISTRAR'S SIGNATURE  |                   |  |                  |
| 136 E. Baltimore St.   |         | Taneytown, Maryland 21787   |                   |  |                  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 4 2 9 7 8 7  
REG. NO.1 - FOR  
STATE  
REGISTRAR

|   |  |  |  |   |                        |   |  |  |  |
|---|--|--|--|---|------------------------|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>KATHERINE H. FAHEY  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>8 20 84 |   | 2b. HOUR<br>11:30 A.M. |   |  |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Jan. 2, 1922  |                        | 6. AGE (IN YEARS LAST BIRTHDAY)<br>62 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                        | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |  |   |                        | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  |                        | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>3501 St. Paul St. 21218  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles Hubbard   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Marie Linton   |                        |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>217-16-8896   |  | 17. INFORMANT<br>5203 Falls Rd.<br>J. Carroll Fahey Baltimore, Md. 21210  |                        |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CHIEF<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) ACUTE MI<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>24 HRS<br>24 HRS |  |  |  |   |                        |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>CANCER LARYNX, ESCAPHAGUS  |  |  |  |   |                        |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |                        | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |                        |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                        |   |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from 29 OCT 19 84, to 8 NOV 19 84, that (he)(we) lost<br>saw the deceased alive on 8 NOV 19 84, and that in (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.  |  |  |  |   |                        |   |  |  |  |
| 22b. SIGNATURE<br>J. Dixon Hills  |  |  |  | DEGREE<br>M.D.  |                        |   |  | 22c. DATE SIGNED<br>8 NOV 84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>J. DIXON HILLS, M.D.   |  |  |  | 22e. ADDRESS<br>201 E. UNIVERSITY PARKWAY   |                        |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation   |  | 23b. DATE<br>Nov. 10, 1984   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Greenmount  |                        | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore City, Maryland                          |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Stewart & Mowen Co. Balto., Md. 21201   |  |  |  | ADDRESS<br>108 W. North Ave   |                        | DATE RECEIVED BY REGISTRAR<br>NGV 13 1984   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.)1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 4 2 9 7 8 9  
REG. NO.

|  |   |   |   |  |   |
|--|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>PEARL Lyde FARRISH</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 03 84</b>  |  | 2b. HOUR<br><b>M</b>  |
| 3 SEX<br><b>Female</b>   | 4. RACE<br><b>Black</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>01 28 02</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>North Carolina</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD                                 |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>John L. Deaton Medical Center</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |   |
| 13a. STATE<br><b>Maryland</b>  |   | 13b. COUNTY<br><b>Baltimore</b>   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS<br><b>2319 David Hill Ave., MD.</b>  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James Boykin Lyde</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary B. Unknown</b>   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>212-18-8280</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>REV. Reginald Daniels 2102 Madison Ave. BALTO. MD.</b>            |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Terminal coma Vigil</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Corbro vascular events</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 week</b><br><b>years</b><br><b>years</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Dehydration - chronic vomiting - renal failure</b>  |   |   |   |  |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 19c. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>9.18 1984</b>   |   | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)<br><b>11.3.84</b> |   |
| 21a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK   |   | 21b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>3809 Grammont Ave Balto 21218</b>        |   |
| 22a. I certify that (this hospital) attended the deceased from <b>9.18 1984</b> to <b>11.3. 1984</b> that (we) last saw the deceased alive on <b>11.3. 1984</b> and that in (my) opinion death occurred on the date and hour and from the causes stated above (If the physician does not view the body after death, check this box.)   |   |   |   |  |   |
| 22b. SIGNATURE<br><b>Vos</b>   |   | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>11.3.84</b>   |   |
| 22d. PHYSICIAN'S NAME (OR PRINT)<br><b>Vos</b>   |   | 22e. ADDRESS<br><b>3809 Grammont Ave Balto 21218</b>  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |   | 23b. DATE<br><b>11/09/1984</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Memorial Park</b>                               |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |   | 24. NUTTER & SONS<br>2501 Gwynns Falls Parkway<br>Funeral Home Inc. Baltimore, Maryland 21216   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 7 1984</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>   |   |   |   |  |   |

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Unknown

For

Lydia

Lydia

212-10-8280

Baltimore, Maryland

11/09/1984 Arthur Memorial Park

Serial

2501 Gaymans Point Parkway

Master & Sons

General Home Inc. Baltimore, Maryland 21210

NOV 9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |                                |  | 8 4 2 9 7 8 8   |     |   |                    |
|--|--|--|--|--|--|---|--|--------------------------------|--|-----------------|-----|---|--------------------|
| 1. FOR STATE REGISTRAR   |  | REG. NO.   |  |  |  |   |  |                                |  |                 |     |   |                    |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST  |  | MIDDLE   |  | LAST  |  | 2a. DATE OF DEATH              |  | MONTH           | DAY | YEAR  | 2b. HOUR           |
| RUTH   |  | E.   |  | FAIR   |  |   |  | 11-05-84                       |  |                 |     |   | 12:20 <sup>A</sup> |
| 3 SEX  |  | 4 RACE   |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR                |  | IF UNDER 24 HRS |     |   |                    |
| Female   |  | White  |  | 11 14 1905   |  | 78 YRS  |  | MONTHS                         |  | DAYS            |     | HOURS MIN.  |                    |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |  |                                |  |                 |     |   |                    |
| Maryland   |  | U.S.A.   |  |  |  | BALTIMORE CITY  |  |                                |  |                 |     | MD.   |                    |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                                |  |                 |     |   |                    |
| BALTIMORE CITY   |  | UNION MEMORIAL HOSPITAL  |  | Saleslady  |  | Retail Dept.  |  |                                |  |                 |     |   |                    |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS / ZIP CODE |  |                 |     |   |                    |
| Md   |  | ---  |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 3625 Falls Road 21211          |  |                 |     |   |                    |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |   |  |                                |  |                 |     |   |                    |
| FIRST MIDDLE LAST  |  | FIRST MIDDLE LAST  |  |  |  |   |  |                                |  |                 |     |   |                    |
| Jacob H. Fair  |  | Clara Jane Stricklin   |  |  |  |   |  |                                |  |                 |     |   |                    |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS   |  |                                |  |                 |     |   |                    |
| no   |  | 217 12 7448  |  | Helen Fair   |  | same  |  |                                |  |                 |     |   |                    |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u>   |  |  |  |  |  |   |  |                                |  |                 |     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>5 DAYS</u> |                    |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |                                |  |                 |     |   |                    |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |  |  |   |  |                                |  |                 |     |   |                    |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |                                |  |                 |     |   |                    |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |  |  |  |  |   |  |                                |  |                 |     |   |                    |
| <u>N/A</u>   |  |  |  |  |  |   |  |                                |  |                 |     |   |                    |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                                |  |                 |     |   |                    |
| <u>N/A</u>   |  | <u>N/A</u>   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                                |  |                 |     |   |                    |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)   |  |   |  |                                |  |                 |     |   |                    |
|  |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |   |  |                                |  |                 |     |   |                    |
|  |  | P.M. 19  |  |  |  |   |  |                                |  |                 |     |   |                    |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION  |  | CITY OR TOWN  |  | COUNTY                         |  | STATE           |     |   |                    |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  |  |  |   |  |                                |  |                 |     |   |                    |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/23</u> , 19 <u>84</u> , to <u>11/5</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>11/5</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |                                |  |                 |     |   |                    |
| 22b. SIGNATURE   |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | 22c. DATE SIGNED  |  |                                |  |                 |     |   |                    |
| <u>Beverly J. Kelsey</u>   |  | M.D.   |  |  |  | <u>11/5/84</u>  |  |                                |  |                 |     |   |                    |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |  |   |  |                                |  |                 |     |   |                    |
| BEVERLY J. KELSEY M.D.   |  | UNION MEMORIAL HOSPITAL  |  |  |  |   |  |                                |  |                 |     |   |                    |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  | CITY OR TOWN                   |  | COUNTY          |     | STATE   |                    |
| Burial   |  | 11/08/84   |  | Druid Ridge Cemetery   |  | Pikesville, Balto. Co. Md.  |  |                                |  |                 |     |   |                    |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |                                |  |                 |     |   |                    |
| NAME   |  | ADDRESS  |  |  |  |   |  |                                |  |                 |     |   |                    |
| Burgee-Henss Funeral Home  |  | 3631 Falls rd. 21211   |  |  |  |   |  |                                |  |                 |     |   |                    |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or after traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   | 8 4 2 9 7 9 0   |   |  |  |
|--|--|---|--|---|---|---|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   | REG. NO.  |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <u>Baby Boy Farrow</u>  |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR <u>9 15 84</u> 2b. HOUR <u>10:52</u> M |   |  |  |
| 3. SEX <u>Male</u>   |  | 4. RACE <u>Black</u>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <u>9 15 84</u>  |   | 6. AGE (IN YEARS LAST BIRTHDAY) <u>—</u> YRS. <u>—</u> MONTHS <u>—</u> DAYS <u>—</u> HRS. <u>—</u> MIN. <u>20</u>                 |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>USA</u>   |  | 7b. CITIZEN OF WHAT COUNTRY? <u>Maryland</u>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>            |   | BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD.   |  |  |
| 10. CITY OR TOWN OF DEATH <u>Baltimore</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>SINAI</u> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |
| 13e. STREET ADDRESS / ZIP CODE <u>00000</u>  |  | 14. FATHER'S NAME FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |   | ADDRESS   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pulmonary Immaturity</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Prematurity</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>51 2011</u>             |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Hypothermia Admission T° 43.3°C</u>  |  |   |  |   |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN VERIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9-15-84</u> to <u>9-15-84</u> , that (I) (we) last saw the deceased alive on <u>9-15-84</u> , and that it is (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |   |   |   |  |  |
| 22b. SIGNATURE <u>Jacob K. Felix, MD</u>   |  | DEGREE <u>MD</u>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED <u>9-15-84</u>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Jacob K. Felix, MD</u>  |  | 22e. ADDRESS <u>Sinai Hospital</u>  |  |   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>   |  | 23b. DATE <u>9-18-84</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Sinai Hospital</u>  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore, Md.</u>   |  |  |
| 24. FUNERAL DIRECTOR NAME <u>Sinai Hospital</u>  |  | 25a. DATE REC'D. BY REGISTRAR <u>NOV 14 1984</u>  |  | 25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>  |   |   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |   |  |
|---|--|--|--|--|--|--|--|---|--|
| 1- FOR STATE REGISTRAR  |  | 7  |  | 8 4  |  | 2 9 7 9  |  | REG. NO.  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>HUBERT FEASTER JR</b>   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 21 84</b>   |  |  |  | 2b. HOUR<br>M<br><b>2:20PM</b>  |  |
| 3 SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 27 52</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><b>32</b>                                 |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                        |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>MD</b>   |  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Hubert Feaster, Sr.</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Nancy Means</b>  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>219-58-6841</b>   |  | 17. INFORMANT ADDRESS<br><b>Hubert &amp; Nancy Feaster 1410 N. Potomac</b>   |  |  |  |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Bran negative bacterial septic shock</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Bone Marrow Failure</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>15 minutes</b><br><b>4 days</b><br><b>2 years</b> |  |  |  |  |  |  |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (b)<br><b>Renal Failure</b> |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                       |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>November 18, 1984</b> to <b>November 21, 1984</b> , that (I) (we) last saw the deceased alive on <b>November 21, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Micheline McCarthy</b>   |  |  |  | DEGREE<br><b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  |  | 22c. DATE SIGNED<br><b>11/21/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Micheline McCarthy</b>  |  |  |  | 22e. ADDRESS<br><b>Nelson 4/Johns Hopkins Hosp/Baltimore, Md.</b>  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11/24/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD</b>                    |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>   |  |  |  | ADDRESS<br><b>1101 E. North Ave.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 23 1984</b>                                  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson</b>  |  |

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NEW YORK



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  | REG. NO. 7 4 2 9 7 9 2   |  |
|---|--|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>WILLIAM B. FENZEL</b>  |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>November 5, 1984</b>                                     |  |  | 2b. HOUR<br><b>7:45</b> M  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 11, 1924</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>60</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4302 Roland Avenue</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Engineer</b>             |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>C&amp;P Tele-</b>  |  |  |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>Balto.</b>   |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>4302 Roland Ave., 21210</b>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Harry G. Fenzel</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Louise Thielke</b>  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II 215 14 0992</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Mary P. Fenzel, Same</b>   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Severe liver failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Portal cirrhosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>10 years</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 year</b><br><b>10 years</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>  |  |  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |  |  |  |  |
| 22a. I certify that (I) (we) (hospital) attended the deceased from <b>June 12, 1961</b> to <b>Nov 5, 1984</b> , that (I) (we) lost<br>saw the deceased alive on <b>Oct. 23, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Marvin Goldstein</b>   |  |  |  |   | DEGREE<br><b>MD</b>  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>Nov. 5, 1984</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Marvin Goldstein, MD</b>  |  |  |  |   | 22e. ADDRESS<br><b>6001 Park Heights Ave., Balto., MD</b>                      |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>11/8/84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer</b>                     |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., MD</b>  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Henry W. Jenkins &amp; Sons Co.</b>  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 7 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randell</b>  |  |  |  |
| 4905 York Road Balto., MD 21212   |  |  |  |   |  |   |  |  |  |  |  |

BP



BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 84 29793<br>REG. NO.   |  |   |  |  |  |
|--|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>GEORGE W. FEREBEE</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 20, 1984</b>  |  |   |  | 2b. HOUR<br><b>12:20a</b>  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 25 13</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>      |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Balto.</b>  |  | 13c. CITY OR TOWN<br><b>Balto.</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>11 W. 20th St. Apt. 16J 21218</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George Ferebee</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Martha Overton</b>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>216-07-3127</b>   |  | 17. INFORMANT ADDRESS<br><b>Martha L. Hollman 453 Ilchester Ave.</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Aspiration Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Multiple Myeloma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____  |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <b>November 8, 1984</b> to <b>November 20, 1984</b> , that (X) (we) lost the deceased alive on <b>November 20, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (do not) view the body after death.                           |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>E. J. [Signature]</b>   |  |   |  | DEGREE<br><b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RAMESH SABAPATHI M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11-24-84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Balto. Cem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>                                 |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Ave.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 21 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |  |

RECEIVED

NOV 10 1964



10/11/64

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Possession may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR<br>1. STATE<br>REGISTRAR   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |   | 8 4 2 9 7 9 4<br>REG. NO.  |                                   |
|--|--|---|---|--|-----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Carlton Ferguson</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 8, 1984</b>  |   | 2b. HOUR<br>M<br><b></b>   |                                   |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Black</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 31 1920</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS.                                    |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S.C</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD                     |                                   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>141 S. Kossuth St.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><b>MD</b>   | 13b. COUNTY  | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>141 S. Kossuth St 21229</b>                                |                                   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Lee Ferguson</b>   |   |  |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>249-18-9741</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Wilhelmina Ferguson 141 S. Kossuth St</b>             |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Diffuse metastatic adeno-</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>carcinoma of the</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>prostate</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b></b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Dx: 79</b> |  |   |   |  |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |   |  |                                   |
| 19a. DATE OF OPERATION<br><b>1979 TURP</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)    |   |  |                                   |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |  |                                   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4</b> 19 <b>81</b> to <b>9</b> 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>9/17</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |   |  |                                   |
| 22b. SIGNATURE<br><b>BEZIRDJIAN, LAWRENCE</b>  |  | DEGREE  |   | 22c. DATE SIGNED   |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BEZIRDJIAN, LAWRENCE</b>   |  | 22e. ADDRESS<br><b>22 S. Greene Street - Balto 21201</b>  |   |  |                                   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11/13/84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Forest VA</b>                      |                                   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Mills Baltimore Md</b>  |  | 23e. DATE REC'D. BY REGISTRAR<br><b>NOV 13 1984</b>   |   |  |                                   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Ave.</b>   |  |   |   |  |                                   |





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH84 29795  
REG. NO.1. FOR  
STATE  
REGISTRAR

|   |  |   |  |   |  |  |   |  |  |
|---|--|---|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>DOVIE</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 03, 1984</b>            |   |  | 2b. HOUR<br><b>2:45 P.M.</b>   |   |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 14, 1899</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Tennessee</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>                         |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  |   | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Dundalk</b>                      |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Blanch Hatfield</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Virginia Foley</b>     |   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no</b> |   |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>212-36-2490</b>  |  |   | 17. INFORMANT<br>ADDRESS<br><b>21222 Margie Williams 106 Williams Ave.</b> |   |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PROSOSLY ACUTE MYOCARDIAL</b><br><b>INFARCTION C.H.F. A.S.C.V.D. OLD MI</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |   |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                           |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                         |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                 |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                               |   |  |  |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)     |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>OCTOBER 25, 1984</b> to <b>NOVEMBER 03, 1984</b> , that (I) (we) last saw the deceased alive on <b>NOVEMBER 03, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.   |  |   |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><i>[Signature]</i><br>ATTENDING MEDICAL STAFF<br>PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>   |  |   |  |   |  | 22c. DATE SIGNED<br><b>11/3/84</b>   |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BIENVENIDO C. VENERACION M.D.</b>   |  |   |  |   |  | 22e. ADDRESS<br><b>CHURCH HOSPITAL CORPORATION<br/>100 NORTH BROADWAY BALTO., MD. 21231</b>                  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>11/7/84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>                             |  |  |
| 24. FUNERAL DIRECTOR<br><b>Connolly Funeral Home of Dundalk</b>   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 14 1984</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |

10

RECEIVED  
JAN 10 1952  
U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

TO : SAC, NEW YORK  
FROM : SAC, NEW YORK  
SUBJECT: [illegible]

RE: [illegible]  
[illegible]  
[illegible]

DATE: [illegible]  
BY: [illegible]  
[illegible]

1. [illegible]  
2. [illegible]  
3. [illegible]

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20. [illegible]  
21. [illegible]

22. [illegible]  
23. [illegible]  
24. [illegible]

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26. [illegible]  
27. [illegible]

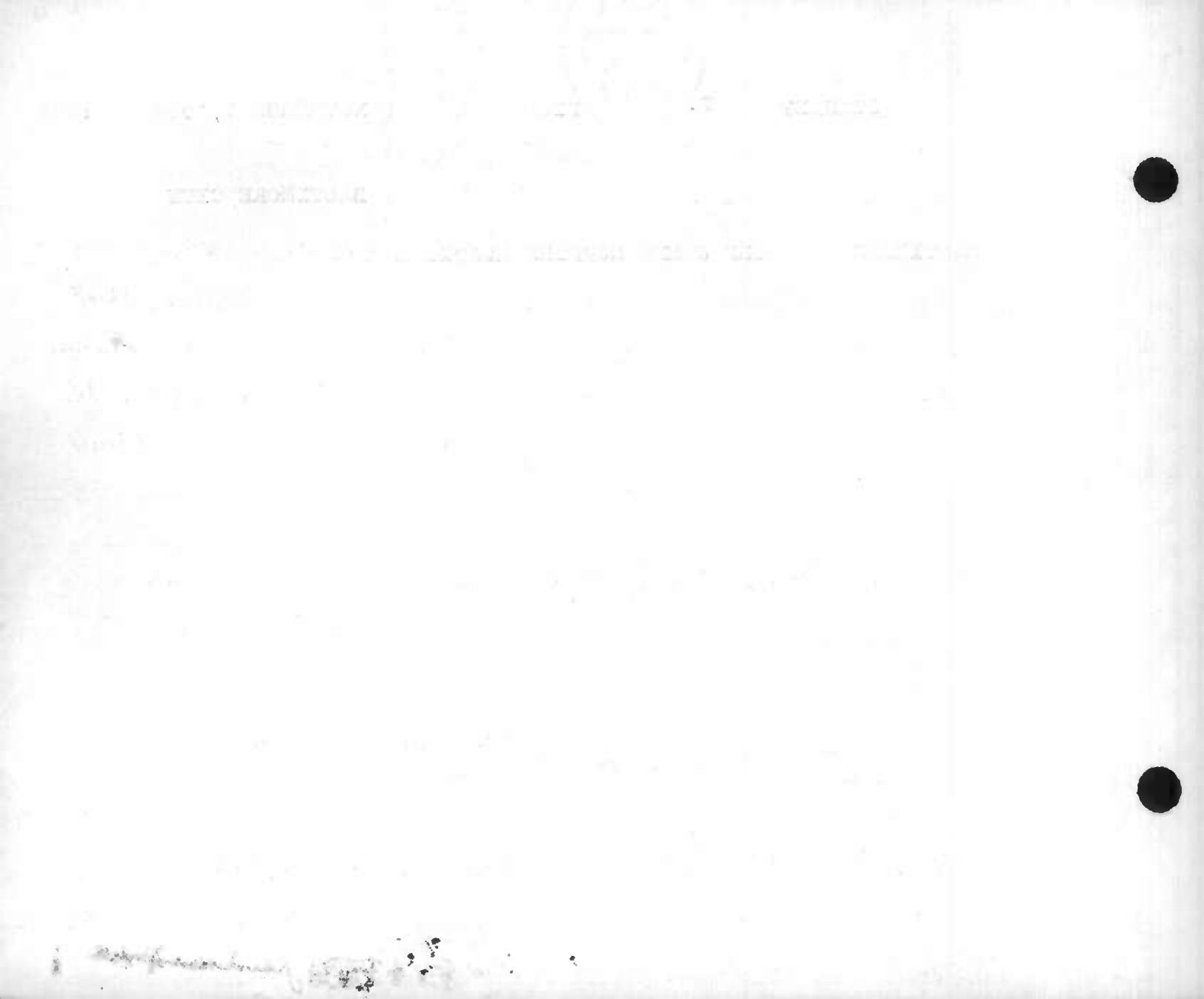
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | 2a. DATE OF DEATH   |  | 2b. HOUR   |  |
|   |  | STANLEY R. FICKES   |  | NOVEMBER 7, 1984  |  | 5:58A <sup>M</sup>   |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>SEPT 13, 1927   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>57 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>FIRE CHIEF (RET.)  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>FIRE DEPT   |  |
| 13a. STATE<br>MD  |  | 13b. COUNTY<br>MONTGOMERY   |  | 13c. CITY OR TOWN<br>ADELPHI  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>WILLIAM C. BACON  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARY ELIZABETH FICKES  |  | 13e. STREET ADDRESS / ZIP CODE<br>2004 EVANSDALE DRIVE 20783  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>216-22-0651  |  | 17. INFORMANT<br>ADDRESS<br>BETTY L. FICKES-2004 EVANSDALE DR.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiopulmonary arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Pseudomonas sinusitis<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 hour           |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 16<br>Pre-leukemia / Peripheral neuropathy / probable vasculitis / perirectal abscess  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTO? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from July 21, 1984 to November 7, 1984, that (I) (we) lost<br>saw the deceased alive on November 7, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Micheline McCarthy  |  | DEGREE<br>MD  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br>Nov. 7, 1984   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Micheline McCarthy   |  | 22e. ADDRESS<br>Nelson 4 / Johns Hopkins Hospital   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>Nov. 11, 1984  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>George Washington Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Adelphi Md   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Takoma Funeral Home J.A. Waters   |  | ADDRESS<br>250 Canal St. NW   |  | 25a. DATE BY REGISTRAR<br>NOV 13 1984   |  |  |  |

MEDICAL CERTIFICATION

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |   |  |  |  | REG. NO. 84 29797   |  |          |  |
|---|--|---|--|--|--|---|--|--|--|---|--|----------|--|
| 1. FOR STATE REGISTRAR  |  |   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |  |  |   |  | 2b. HOUR |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Ruth I. Figgs   |  |   |  |  |  | November 26, 1984   |  |  |  |   |  | M        |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>6 30 00   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN.                                   |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>      |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |  |  |   |  |          |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Union Memorial Hospital 21218 |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                      |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |          |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>--   |  | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>3974 Edgehill Ave. 21211   |  |   |  |          |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>William Granville Jones  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Carrie Anthony   |  |   |  |  |  |   |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>--  |  | 17. INFORMANT ADDRESS<br>214-10-6289 Mr. William Figgs 25 Acorn Circle 21204   |  |   |  |  |  |   |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u>   |  |   |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>middle</u> |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive cv disease</u>   |  |   |  |  |  |   |  |  |  | 1968  |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |   |  |  |  |   |  |  |  |   |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>no</u>  |  |   |  |  |  |   |  |  |  |   |  |          |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |  |  |   |  |          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |   |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Aug. 8</u> 19 <u>88</u> to <u>NOV/20</u> 19 <u>84</u> that (I) (we) lost saw the deceased alive on <u>Aug. 31</u> 19 <u>84</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |  |  |   |  |          |  |
| 22b. SIGNATURE<br><u>Reuben Hoffman</u>   |  |   |  | DEGREE <u>M.D.</u><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br>11-27-84   |  |   |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Reuben Hoffman   |  |   |  | 22e. ADDRESS<br>846 W. 36th Street 21211   |  |   |  |  |  |   |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>11/29/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Denton Cemetery  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Denton Maryland                                      |  |  |  |   |  |          |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br>A. Alan Seitz Funeral Home 21211 3818 Roland Ave.  |  |   |  |  |  |   |  |  |  |   |  |          |  |



ORIGINAL

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Kaufmann  
Kaufmann

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FINCH, LUZENIA  
02/22/08 7.9 / 9 8  
REG. NO.

FOR  
1- STATE  
REGISTRAR

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>LUZENIA Cornitcher FINCH</b>     |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 10 84</b>  |  | 2b. HOUR<br><b>8:46PM</b>   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 22 08</b>              |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>76</b>   |  | 8. IF UNDER 24 HRS.<br>HOURS MIN.<br><b>76</b>                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>North Carolina</b>                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b> |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)         |  |  |  |   |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Balto.</b>   |  | 13c. CITY OR TOWN<br><b>Balto.</b>                                |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>931 N. Washington St. 21205</b>   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Jacobs</b>                                    |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Addie Carr</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>               |  | 16b. SOCIAL SECURITY NO.<br><b>241-16-6175A</b>  |  | 17. INFORMANT<br><b>Queenie Jacobs</b>                            |  |
| 17. ADDRESS<br><b>931 N. Washington St.</b>   |  |  |  |   |  |

|  |  |  |  |
|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY Arrest</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>10 min</b> |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>HYPOTENSION</b>   |  | <b>2 HRS.</b>  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>COAGULOPATHY</b>  |  | <b>3 HRS.</b>  |  |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

**Abdominal Aortic Aneurysm**

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 19a. DATE OF OPERATION<br><b>11/10/84</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>AORTIC ANEURYSM</b> |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>               |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)     |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 10</b> , 19 <b>84</b> , to <b>Nov 10</b> , 19 <b>84</b> . That (I) (we) last saw the deceased alive on <b>Nov 10</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE<br><b>CHARLES JOHN YEO</b>  |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>11/10/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CHARLES JOHN YEO</b>   |  | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL</b>                              |  |  |  |

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>              |  | 23b. DATE<br><b>11-16-84</b>                        |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md. National Cem</b> |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Laurel Md.</b>            |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H 1101 E. North Ave.</b> |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 13 1984</b> |  | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 above any injury, or other traumatic event, the medical examiner must be notified at once.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |   |   |   | REG. NO. 84 29799  |   |
|---|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Marie Finniaty</i>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>11/11/84</i>                                  |  | 2b. HOUR<br><i>9:01</i> M                             |
| 3. SEX<br><i>female</i>   | 4. RACE<br><i>white</i>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>3 1 03</i>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>81</i> YRS.<br># UNDER 1 YEAR MONTHS DAYS # UNDER 24 HRS. HOURS MIN. |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>MARYLAND</i>  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>BALTIMORE CITY</i> MD.  |   |
| 10. CITY OR TOWN OF DEATH<br><i>BALTO.</i>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>FRANCIS SCOTT KEY HOSP.</i> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>CANDY DIPPER</i> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>CANDY CO.</i> |
| 13a. STATE<br><i>MD.</i>  |   | 13b. COUNTY<br><i>—</i>   | 13c. CITY OR TOWN<br><i>BALTO.</i>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>WILLIAM OUTTEN</i>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>ELIZABETH TOWNSEND</i>              |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>   |   | 16b. SOCIAL SECURITY NO.<br><i>215-22-9021</i>  |   | 17. INFORMANT ADDRESS<br><i>Mr. John Finniaty - 209 S. Wolfe St., 21231</i>                                |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>cardiopulm. arrest</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>massive pulmonary embolism (suggested)</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>—</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>—</i>   |   |   |   |  |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>— P.M. 19</i>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                             |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11/5/84</i> 19 <i>84</i> to <i>11/11/84</i> 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>11/11</i> 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                              |   |   |   |  |   |
| 22b. SIGNATURE<br><i>Joseph A. Carrese</i>  |   | DEGREE <i>MD</i><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>         |   | 22c. DATE SIGNED<br><i>11/11/84</i>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Joseph A. Carrese</i>   |   | 22e. ADDRESS<br><i>FSK MC, Balt., MD.</i>   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>BURIAL</i>  |   | 23b. DATE<br><i>11-14-84</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>ST. STANISLAUS CEM.</i>   |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>BALTO., MD.</i>  |   | 23e. DATE REC'D. BY REGISTRAR<br><i>NOV 14 1984</i>   |   |  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Barth Spill</i>  |   | ADDRESS<br><i>- 2334 Jefferson St</i>   |   | 25a. REGISTRAR'S SIGNATURE<br><i>Lila Davidson-Randall</i>   |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the health officer with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |   |  | 8 4 2 9 8 0 0   |  |   |  |                                   |  |
|---|--|--|--|---|--|--|--|---|--|---|--|---|--|-----------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.   |  |   |  |  |  |   |  |   |  |   |  |                                   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br>Reinhold  |  | MIDDLE<br>M.  |  | LAST<br>Fischer  |  | 2a. DATE OF DEATH<br>MONTH<br>11  |  | DAY<br>21   |  | YEAR<br>84  |  | 2b. HOUR<br>M                     |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH<br>8  |  | DAY<br>21  |  | YEAR<br>02  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82   |  | IF UNDER 1 YEAR<br>MONTHS<br>YRS.                           |  | IF UNDER 24 HRS.<br>HOURS<br>MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN<br>COUNTRY)<br>Baltimore, Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                 |  |   |  |   |  |   |  |                                   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore City   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Francis Scott Key Hospital              |  |   |  |  |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>retired farmer              |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>Self-employed       |  |                                   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   |  |  |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>9772 Bird River Rd. 21220 |  |                                   |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST<br>Selma<br>MIDDLE<br>Schoenfeld<br>LAST |  |   |  |   |  |   |  |                                   |  |
| 14. FATHER'S NAME<br>FIRST<br>Paul<br>MIDDLE<br>John<br>LAST<br>Fischer   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>220-34-6463A  |  | 17. INFORMANT<br>ADDRESS<br>Carl Stumpf 9750 Bird River Rd. 21220          |  |   |  |   |  |   |  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u>   |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>Immed</u>                                 |  |   |  |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ASCVD</u>  |  |  |  |   |  |  |  |   |  | 30 years  |  |   |  |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |  |   |  |  |  |   |  |   |  |   |  |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |  |   |  |   |  |   |  |                                   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |   |  |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |   |  |   |  |                                   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |   |  |   |  |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (If (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |   |  |   |  |   |  |                                   |  |
| 22b. SIGNATURE<br><u>John Littleton</u>   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  |  |  |   |  | 22c. DATE SIGNED  |  |   |  |                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>John Littleton, M. D.  |  | 22e. ADDRESS<br>1012 Old North Point Rd. (Phone 285-2110)  |  |   |  |  |  |   |  |   |  |   |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>11-23-84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Zion Cemetery   |  |  |  | 23d. LOCATION<br>CITY OR TOWN<br>Baltimore, Maryland  |  |   |  |   |  |                                   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>LASSA HN FUNERAL HOME   |  | 24a. DATE REC'D. BY REGISTRAR<br>NOV 27 1984   |  | 24b. REGISTRAR'S SIGNATURE<br><u>Davidson-Randall</u>   |  |  |  |   |  |   |  |   |  |                                   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the deceased, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |   |   |   |  |   |
|---|--|--|--|--|---|---|---|--|---|
| 1. FOR STATE REGISTRAR  |  |  |  |  | 84 29801<br>REG. NO.  |   |   |  |   |
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>William Perry Fisher SR.</b>  |  |  |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR <b>Nov. 27, 1984</b>   |   |   | 2b HOUR<br><b>545 P.M.</b>                               |   |
| 3 SEX<br><b>MALE</b>  |  | 4 RACE<br><b>WHITE</b>   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR <b>12 24 15</b>  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                |   |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>INDIANA</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |   |  |   |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSPITAL</b> |  |  |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>ELEC. DIESEL ENG.</b>                   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>ELECTRICAL</b>   |   |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>---</b>  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |   | 13d. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> |   | 13e STREET ADDRESS<br><b>925 ROCK HILL AVENUE, 21229</b> |   |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN FISHER</b>   |  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MYRTLE UNKNOWN</b>  |   |   |   |  |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>   |  | 16b SOCIAL SECURITY NO.<br><b>WW II</b>  |  | 17. INFORMANT<br><b>ARTHUR G. MABEN</b>  |   | ADDRESS<br><b>4202 WILKENS AVENUE, 21229</b>  |   |  |   |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>CONGESTIVE HEART FAILURE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>RHEUMATIC VALVULITIS</b> |  |  |  |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |  |  |  |   |   |   |  |   |
| 19a DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                     |  |   |   | 20a AUTOPSY?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>     |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                             |   |   |  |   |
| 21d INJURY OCCURRED<br><input type="checkbox"/> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK  |  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY OFFICE, FARM, ETC.) |  | 21i LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |   |
| 22a I certify that <del>the</del> (this hospital) attended the deceased from <b>Nov 27, 19 84</b> , to <b>Nov 27, 19 84</b> , that <del>the</del> (we) last saw the deceased alive on <b>Nov 27, 19 84</b> , and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above, (I <del>we</del> ) (did) (did not) view the body after death.        |  |  |  |  |   |   |   |  |   |
| 22b SIGNATURE<br><b>Bert F. Morton M.D.</b>   |  |  |  |  | DEGREE<br><b>M.D.</b>   |   |   | 22c DATE SIGNED<br><b>11/27/84</b>                       |   |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BERT F. MORTON</b>   |  |  |  |  | 22e ADDRESS<br><b>ST. AGNES HOSPITAL, 900 S. CATON AVENUE</b>   |   |   |  |   |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b DATE<br><b>11-30-84</b>  |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK</b>  |   |   | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE CITY MARYLAND</b>                       |  |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229</b>   |  |  |  |  | 25a DATE REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE<br><b>NOV 30 1984</b> <i>John Davidson-Randall</i> |   |   |  |   |

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William J. Frank



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner may be notified or called.

## MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 4 2 9 8 0 2<br>REG. NO.  |  |  |  |
|--|--|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>HAROLD A FITZGERALD</b>  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov 23 1984</b>   |  |   |  | 2b. HOUR<br><b>10:30 A M</b>   |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 25 1922</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b>  |  | 7. UNDER 1 YEAR<br>MONTHS DAYS   |  | 8. UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Massachusetts</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>                   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Keswick House Nursing Home</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Engineer</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Fed. Gov't.</b>  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br><b>Maryland Prince George Temple Hills</b>  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>5055 St. Barnabas Rd. 20748</b>                |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unknown Fitzgerald</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>   |  |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Yes WWII</b>                        |  |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>020-18-0636</b>   |  |  |  | 17. INFORMANT<br><b>Sally M. Harkins</b>  |  |   |  | ADDRESS<br><b>5055 St. Barnabas Rd. Temple Hills, Md.</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Aspiration Pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Bilateral CVA with Tracheostomy &amp; Gastrostomy</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>SIRS</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>4 days</u>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a  |  |  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)      |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                   |  |  |  |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>17 April 84</u> to <u>23 Nov 84</u> , that (I) (we) last saw the deceased alive on <u>23 Nov 84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Anthony D. Richardson</u>   |  |  |  | DEGREE<br><u>M.D.</u>   |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><u>23 Nov 1984</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A. D. Richardson, M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>700 W. 40th St., Baltimore, Md.</b>  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |  |  | 23b. DATE<br><b>11/26/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lakemont Mem. Gardens</b>                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Davidsonville A.A. Maryland</b>   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>George P. Kalas Funeral Home</b>  |  |  |  | ADDRESS<br><b>6160 Oxon Hill Rd. Oxon Hill, Md.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 26 1984</b>                                 |  | 25b. REGISTRAR'S SIGNATURE<br><u>Richardson</u>  |  |  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_  
DHMH - 17  
(VR A15 ME (5))

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |         |                  |  |   |                  |  |                |   |   |          |  |   |  |  |
|---|---------|------------------|--|---|------------------|--|----------------|---|---|----------|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         |                  | FIRST MIDDLE LAST  |   |                  | 2a. DATE KNOWN OF DEATH  |                |   | MONTH DAY YEAR  |          |  | 2b. HOUR  |  |  |
| PHILIP FLAX   |         |                  |  |   |                  | 11-12-84   |                |   |   |          |  |   |  |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS)  | IF UNDER 1 YR.  | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD   | MONTH DAY YEAR |   |   | 2d. HOUR |  |   |  |  |
| MALE  | WHITE   | MAR. 23, 1902    | 82 YRS.  |   |                  | 11-12-84   |                |   |   | 3:50P    |  |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         |                  | 7b. CITIZEN OF WHAT COUNTRY?                             |   |                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                |   | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |          |  |   |  |  |
| MARYLAND  |         |                  | USA  |   |                  |  |                |   | Baltimore City  |          |  |   |  |  |
| 10. CITY OR TOWN OF DEATH   |         |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |   |                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |                |   | 12b. KIND OF BUSINESS OR INDUSTRY                                   |          |  |   |  |  |
| Baltimore   |         |                  | Church Hospital  |   |                  | MERCHANT SEAMAN  |                |   | SHIPPING  |          |  |   |  |  |
| 13a. STATE  |         |                  | 13b. COUNTY  |   |                  | 13c. CITY OR TOWN  |                |   | 13d. INSIDE CITY LIMITS?  |          |  | 13e. STREET ADDRESS   |  |  |
| MARYLAND  |         |                  |  |   |                  | BALTIMORE  |                |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |          |  | 15 N. PATTERSON PARK AVE. 21231                                     |  |  |
| 14. FATHER'S NAME   |         |                  | 15. MOTHER'S MAIDEN NAME                                 |   |                  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |                |   | 16b. SOCIAL SECURITY NO.  |          |  | 17. INFORMANT   |  |  |
| MANUEL FLAX   |         |                  | MARY BLISSOFF  |   |                  | NO   |                |   | 064-12-5125   |          |  | MISS LILLIAN M. SHERMAN   |  |  |
|   |         |                  |  |   |                  | (IF YES, GIVE WAR OR DATES)  |                |   |   |          |  | 4419 PIMLICO RD. BALTO., MD 21215                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         |                  |  |   |                  |  |                |   |   |          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |  |
| PART 1 DEATH WAS CAUSED BY:   |         |                  |  |   |                  |  |                |   |   |          |  |   |  |  |
| IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>  |         |                  |  |   |                  |  |                |   |   |          |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |         |                  |  |   |                  |  |                |   |   |          |  |   |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |         |                  |  |   |                  |  |                |   |   |          |  |   |  |  |
| (b) _____   |         |                  |  |   |                  |  |                |   |   |          |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |         |                  |  |   |                  |  |                |   |   |          |  |   |  |  |
| (c) _____   |         |                  |  |   |                  |  |                |   |   |          |  |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |         |                  |  |   |                  |  |                |   |   |          |  |   |  |  |
| <u>diabetes mellitus and carcinoma</u>  |         |                  |  |   |                  |  |                |   |   |          |  |   |  |  |
| 19a. DATE OF OPERATION  |         |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |                  |  |                |   |   |          |  | 20. AUTOPSY?  |  |  |
|   |         |                  |  |   |                  |  |                |   |   |          |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |                  |  | 21b. TIME OF INJURY   |                  |  |                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |          |  |   |  |  |
|   |         |                  |  | HOUR A.M. MONTH DAY YEAR                                    |                  |  |                |   |   |          |  |   |  |  |
|   |         |                  |  | P.M. 19   |                  |  |                |   |   |          |  |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |         |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |                  |  |                | 21f. LOCATION   |   |          |  |   |  |  |
|   |         |                  |  |   |                  |  |                | CITY OR TOWN COUNTY STATE   |   |          |  |   |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |                  |  |   |                  |  |                |   |   |          |  |   |  |  |
| ACTUAL SIGNATURE  |         |                  |  | TITLE (SPECIFY)   |                  |  |                | DATE SIGNED   |   |          |  |   |  |  |
| <u>Margarita A. Korell</u>  |         |                  |  | M.D. Assistant  |                  |  |                | 11-13-84  |   |          |  |   |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |         |                  |  | ADDRESS   |                  |  |                |   |   |          |  |   |  |  |
| Margarita A. Korell, M.D.   |         |                  |  | 111 Penn Street   |                  |  |                |   |   |          |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |         |                  |  | 23b. DATE   |                  |  |                | 23c. NAME OF CEMETERY OR CREMATORY  |   |          |  | 23d. LOCATION   |  |  |
| BURIAL  |         |                  |  | NOV. 13, 1984   |                  |  |                | GREATER BALTO. LODGE  |   |          |  | BALTIMORE   |  |  |
|   |         |                  |  |   |                  |  |                |   |   |          |  | COUNTY STATE  |  |  |
|   |         |                  |  |   |                  |  |                |   |   |          |  | MARYLAND  |  |  |
| 24. FUNERAL DIRECTOR NAME   |         |                  |  | ADDRESS   |                  |  |                | 25a. DATE RECD. BY REGISTRAR  |   |          |  | 25b. REGISTRAR'S SIGNATURE  |  |  |
| SOL LEVINSON & BROS., INC.  |         |                  |  |   |                  |  |                | NOV 20 1984   |   |          |  | <u>[Signature]</u>  |  |  |
| 6010 REISTERSTOWN RD. BALTO., MD 21215  |         |                  |  |   |                  |  |                |   |   |          |  |   |  |  |

13813 MATTOO NO.2

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

|   |                         |  |  |   |  |
|---|-------------------------|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>William Fleet</b>   |                         |  | 2a. DATE KNOWN OF DEATH<br><input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>11-27-84</b> |   | 2b. HOUR<br><b>9:48P</b>                     |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>Black</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 19 22</b>   | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br><b>62 YRS.</b>   | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>11-27-84</b>                       | 7d. HOUR<br><b>19</b>                        |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>                       |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1832 N. Caroline Street</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                       |  |
| 12b. KIND OF BUSINESS OR INDUSTRY   |                         | 13. RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |
| 13a. STATE<br><b>MD</b>   | 13b. COUNTY             | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  | 13e. STREET ADDRESS<br><b>1832 N. Caroline St.</b>                                  |  |
| 14. FATHER'S NAME<br>(FIRST MIDDLE LAST)  |                         |  | 15. MOTHER'S MAIDEN NAME<br>(FIRST MIDDLE LAST)<br><b>Annie Fleet</b>                            |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>Yes</b>   |                         | 16b. SOCIAL SECURITY NO.<br><b>N/A</b>   |  | 17. INFORMANT ADDRESS<br><b>Florence Wallace 1832 N. Caroline St</b>                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |                         |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I  |                         |  |  |   |  |
| 19a. DATE OF OPERATION  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                         |  |  |   |  |
| ACTUAL SIGNATURE<br><b>Margarita A. Korell</b>  |                         | TITLE (SPECIFY)<br><b>Assistant</b>  |  | DATE SIGNED<br><b>11-27-84</b>  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Margarita A. Korell, M.D.</b>  |                         | ADDRESS<br><b>111 Penn Street</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |                         | 23b. DATE<br><b>12/3/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Forest VA</b>                     |  |
| 23d. LOCATION<br>CITY OR TOWN<br><b>Owings Mills</b>  |                         | COUNTY<br><b>MD</b>  |  | STATE   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>   |                         | ADDRESS<br><b>1101 E. North Ave.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 29 1984</b>                                 |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Jane Garrison</b>  |                         |  |  |   |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

07/84  
25M

BP  
DHMH - 17  
(VR A15 ME (5))

ONE

ONE

WATER

MOTION 000



Handwritten signature or text at the bottom center.



Handwritten marks or numbers in the top right corner.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this document has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 4 2 9 8 0 5<br>REG. NO.   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>JEAN CAROLYN FLETCHER   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>11 20 84  |  | 2b. HOUR<br>1130   |  |
| 1. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>2 28 45  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>39 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Parts Mgr.   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Equip. Co.  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>Md.  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>George O. Wilhelm   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Shirley Wheeler   |  | 13e. STREET ADDRESS / ZIP CODE<br>1602 Twin Maple Road 21204  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>no  |  | 16b. SOCIAL SECURITY NO.<br>213-46-4863   |  | 17. INFORMANT ADDRESS<br>Mr. William O. Fletcher, Baltimore, Md.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>MIDDLE CEREBRAL ARTERY ANEURYSM BLEED</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>INTRACRANIAL HERNIATION</u> |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.<br><u>NONE</u>  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br>11/14/84   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>BLEEDING INTRACRANIAL ANEURYSM  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF ENTER, NOTIFY MEDICAL EXAMINER)<br>P.M. 19   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input checked="" type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from 11/14/1984 to 11/20/1984, that (we) last saw the deceased alive on 11/20/1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.                 |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Peter Wallick MD   |  |   |  | DEGREE<br>MD  |  | 22c. DATE SIGNED<br>11/20/84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Peter Wallick   |  |   |  | 22e. ADDRESS<br>201 E. UNIVERSITY PARKWAY<br>BALTIMORE, MD 21218  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>11-23-84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Hampstead Cemetery  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Hampstead Carroll Md.   |  |
| 24. FUNERAL DIRECTOR NAME<br>Eline Funeral Home, Hampstead, Md.  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 26 1984  |  |  |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |  |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 8 0 6

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |   |  |  |   |
|--|--|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Inez Florey</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 12 84</b>                               |  | 2b. HOUR<br><b>9:15P M</b>  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 30 04</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.                              |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>U.S.A.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.              |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Mt. Vernon Care Center, Inc.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  |
| 13a. STATE<br><b>Md.</b>   |  |   | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George T. Danner</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Bessie C. Price</b>              |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  | 17. INFORMANT ADDRESS<br><b>Kathleen Reemsnyder 1264 Maple Ave 21227</b>       |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIOSCLEROTIC CVD</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.<br><b>ALZHEIMER'S DISEASE, CBS, DIABETES MELLITUS</b>   |  |   |  |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/01</b> , 19 <b>84</b> , to <b>11/12</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>11/12</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.          |  |   |  |  |   |
| 22b. SIGNATURE<br><b>Enrique</b><br>DEGREE<br><b>MD</b>  |  |   |  | 22c. DATE SIGNED<br><b>11-12-84</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A. C. ENRIQUE</b>  |  |   |  | 22e. ADDRESS<br><b>2435 W BELVEDERE 21215</b>                                  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>   |  | 23b. DATE<br><b>11/15/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge</b>                       |   |
| 23d. LOCATION<br>CITY OR TOWN<br><b>Dorsey</b>   |  | COUNTY<br><b>Howard</b>   |  | STATE<br><b>Md.</b>  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Amber Inc. 1328 Salphur Rd.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 14 1984</b>                            |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>J. B. [Signature]</b>   |  |   |  |  |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

• • •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers, pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, then medical examiner must be notified and noted.

DHMH - 16 50M 4/83  
(VRA 15, 4)

| STATE OF MARYLAND  |  |  |  |  |   |  |                                |  |  |
|--|--|--|--|--|---|--|--------------------------------|--|--|
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  | 8 4 2 9 8 0 7                             |  |                                |  |  |
| 1 - FOR STATE REGISTRAR  |  |  |  |  | CERTIFICATE OF DEATH                      |  |                                |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  |  | 2a. DATE OF DEATH                         |  |                                |  |  |
| FIRST MIDDLE LAST  |  |  |  |  | MONTH DAY YEAR                            |  |                                |  |  |
| CHRISTINA ANN FLYNN  |  |  |  |  | 11 / 1 / 84                               |  |                                |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |   | 6. AGE (IN YEARS LAST BIRTHDAY)  |                                | 7b. HOUR   |  |
| FEMALE   |  | WHITE  |  | MONTH DAY YEAR   |   | 91 YRS   |                                | 12 <sup>NA</sup> M   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                                |  |  |
| Maryland   |  | U.S.A.   |  |  |   | Baltimore City   |                                | MD.  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |                                | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Baltimore  |  | Caton Manor Nursing Home   |  |  |   | Homemaker  |                                | ---  |  |
| 13a. STATE   |  |  |  |  | 13b. CITY OR TOWN                         |  | 13c. STREET ADDRESS / ZIP CODE |  |  |
| Maryland   |  |  |  |  | Howard                                    |  | Ellicott City                  |  |  |
| 14. FATHER'S NAME  |  |  |  |  | 15. MOTHER'S MAIDEN NAME                  |  |                                |  |  |
| FIRST MIDDLE LAST  |  |  |  |  | FIRST MIDDLE LAST                         |  |                                |  |  |
| William Spink  |  |  |  |  | Augusta Nau                               |  |                                |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  |  | 16b. SOCIAL SECURITY NO.                  |  | 17. INFORMANT ADDRESS          |  |  |
| NO   |  |  |  |  | 215-09-5790                               |  | 21043                          |  |  |
|  |  |  |  |  | Minetta C. Beauchamp 3363 B N Chatham Rd. |  |                                |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |   |  |                                |  |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |   |  |                                |  |  |
| IMMEDIATE CAUSE (a) <i>Myocardial infarction</i>   |  |  |  |  |   |  |                                |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Cardiovascular disease</i>  |  |  |  |  |   |  |                                |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |  |   |  |                                |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):  |  |  |  |  |   |  |                                |  |  |
| <i>Coronary Arteriosclerosis - (R) Karyophylla</i>   |  |  |  |  |   |  |                                |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED |  |   | 20a. AUTOPSY?  |                                | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |  |  |   | YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY                              |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                                |  |  |
|  |  |  | HOUR A.M. MONTH DAY YEAR                         |  |   |  |                                |  |  |
| 21d. INJURY OCCURRED   |  |  | 21e. PLACE OF INJURY                             |  |   | 21f. LOCATION  |                                |  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  |  |  | (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)    |  |   | STREET CITY OR TOWN COUNTY STATE   |                                |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>8-5-80</i> to <i>11-1-84</i> that (I) (we) last saw the deceased alive on <i>10-14-84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |  |                                |  |  |
| 22b. SIGNATURE   |  |  | DEGREE   |  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                | 22c. DATE SIGNED   |  |
| <i>D. Saluja</i>   |  |  |  |  |   |  |                                | 11/1/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  | 22e. ADDRESS                                     |  |   |  |                                |  |  |
| D. SALUJA, M.D.  |  |  | 1600 MOUNT ROYAL AVENUE                          |  |   |  |                                |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY        |  | 23d. LOCATION                  |  |  |
| Burial   |  |  | 11/5/84  |  | New Cathedral Cem.                        |  | Baltimore                      |  |  |
|  |  |  |  |  |   |  | Maryland                       |  |  |
| 24. FUNERAL DIRECTOR   |  |  | NAME   |  | ADDRESS                                   |  | DATE RECEIVED BY REGISTRAR     |  |  |
| Hubbard Funeral Home, Inc.   |  |  | 4107 Wilkens Ave.                                |  | 21229                                     |  | NOV 2 1984                     |  |  |

MEDICAL CERTIFICATION

and, after a while, I have

just a few more to add

to the list of things I have

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |  |  |  |  | 84 29808                                 |  |
|---|--|---|--|--|--|--|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.  |  |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br>ALBERTA  |  | MIDDLE   |  | LAST<br>FOGLE  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>NOV. 11/5/84  |  | 2b. HOUR<br>M                            |  |
| 3 SEX<br>Female   |  | 4 RACE<br>Negro   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>7/12/1910   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>74<br>YRS.   |  | 7 UNDER 1 YEAR<br>MONTHS DAYS  |  | 8 UNDER 24 HRS<br>HOURS MIN              |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia  |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3700 Harlem Avenue |  |  |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>housewife   |  | 12b KIND OF BUSINESS OR INDUSTRY<br>none |  |
| 13a STATE<br>MD.  |  | 13b COUNTY  |  | 13c CITY OR TOWN<br>Baltimore  |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e STREET ADDRESS<br>21229<br>832 Allendale Street  |  |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Long  |  |   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Tina   |  |  |  | 16 ADDRESS<br>3700 Harlem Avenue 21229   |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>217-26-5074   |  | 17 INFORMANT<br>FLORENCE THORNTON FOGLE  |  |  |  | 18 ADDRESS<br>3700 Harlem Avenue 21229   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Diffuse histiocytic Lymphoma</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>10 months</u>      |  |   |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>Hepatitis B</u>  |  |   |  |  |  |  |  |  |  |  |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |  |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from <u>July 9</u> , 19 <u>84</u> , to <u>Nov 3</u> , 19 <u>84</u> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <u>Oct 3</u> , 19 <u>84</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above; (I) <input type="checkbox"/> did not view the body after death. |  |   |  |  |  |  |  |  |  |  |  |
| 22b SIGNATURE<br><u>Paul E. Gormley</u>   |  |   |  | DEGREE<br>MD   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c DATE SIGNED<br><u>11/6/84</u>  |  |  |  |
| 22e PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>PAUL E. GORMLEY</u>  |  |   |  | 22f ADDRESS<br><u>900 CATON AVE BALTO. MD 21229</u>  |  |  |  |  |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b DATE<br>11/07/84  |  | 23c NAME OF CEMETERY OR CREMATORY<br>BALTIMORE CEMETERY  |  | 23d LOCATION<br>BALTIMORE  |  | COUNTY<br>MARYLAND   |  |  |  |
| 24 FUNERAL DIRECTOR<br>MARSHALL W. JONES, JR.<br>4101 EDMONDSON AVE, BALTO., Md. 21229  |  |   |  | 25a DATE REC'D. BY REGISTRAR<br>NOV 7 1984   |  | 25b REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |  |  |  |  |





DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

|  |  |  |  |   |  |   |  |   |  |                               |  |  |  |              |  |   |  |   |  |                        |  |
|--|--|--|--|---|--|---|--|---|--|-------------------------------|--|--|--|--------------|--|---|--|---|--|------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br>JAMES   |  | MIDDLE<br>A.  |  | LAST<br>FORD  |  | 2b. DATE KNOWN<br>OF DEATH<br>ESTI-<br>MATED                                  |  | MONTH<br>11                   |  | DAY<br>6   |  | YEAR<br>1984 |  | 2b HOUR<br>M  |  |   |  |                        |  |
| 3. SEX<br>male   |  | 4. RACE<br>Col   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1-4-20 64   |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)<br>YRS.  |  | IF UNDER 1 YR.<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN |  | 7c. DATE<br>PRONOUNCED<br>DEAD   |  | MONTH<br>11  |  | DAY<br>6  |  | YEAR<br>1984                                    |  | 2d HOUR<br>4:26<br>P M |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                       |  |   |  |                               |  |  |  |              |  |   |  |   |  |                        |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1911 Druid Hill Ave. |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF PREVIOUS YEAR)<br>Retired  |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY<br>-   |  |   |  |                               |  |  |  |              |  |   |  |   |  |                        |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>BALTO.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>1911 Druid Hill Ave                                    |  |                               |  |  |  |              |  |   |  |   |  |                        |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James A. Ford SR.  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Maggie W. Ford  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>yes WWII   |  |   |  |   |  |                               |  |  |  |              |  |   |  |   |  |                        |  |
| 16b. SOCIAL SECURITY NO.<br>217-16-0349A   |  | 17. INFORMANT<br>Mr. George 3228 Liggett Key 21216   |  |   |  |   |  |   |  |                               |  |  |  |              |  |   |  |   |  |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a). Hypertensive cardiovascular disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause last<br>(b).<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c).  |  |  |  |   |  |   |  |   |  |                               |  |  |  |              |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |                        |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 1a:   |  |  |  |   |  |   |  |   |  |                               |  |  |  |              |  |   |  |   |  |                        |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  |                               |  |  |  |              |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |                        |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |                               |  |  |  |              |  |   |  |   |  |                        |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   |  |  |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |                               |  |  |  |              |  |   |  |   |  |                        |  |
| 22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion<br>death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |  |  |   |  |   |  |   |  |                               |  |  |  |              |  |   |  |   |  |                        |  |
| ACTUAL<br>SIGNATURE<br>Ann M. Dixon  |  |  |  | M.D. Assistant MEDICAL EXAMINER   |  |   |  |   |  |                               |  |  |  |              |  | DATE<br>SIGNED 11-7-84  |  |   |  |                        |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |  |  |  | Ann M. Dixon, M.D.  |  |   |  |   |  |                               |  |  |  |              |  |   |  |   |  |                        |  |
| ADDRESS  |  |  |  | 111 Penn St., Balto., Md. 21201   |  |   |  |   |  |                               |  |  |  |              |  |   |  |   |  |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE)  |  |  |  | 23b. DATE<br>11-9-84  |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>GARRISON Forest                         |  |                               |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Bellevue Queens Mill Md. |  |              |  |   |  |   |  |                        |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  |  |  | Joseph L. Russ  |  |   |  | ADDRESS<br>2222 W. North Ave.   |  |                               |  | 25. DATE REC'D. BY REGISTRAR<br>NOV 9 1984                             |  |              |  | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randall                                 |  |   |  |                        |  |

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH PAGE 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

CHOW FISH

AND



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 8 1 0

REG. NO.

|   |  |   |  |   |  |  |  |  |  |  |  |
|---|--|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Taylor HENRY Ford</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11-6-84</b>                     |   |  | 2b. HOUR<br><b>12 10 P M</b>   |  |  |  |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>BLK.</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>AUG 10 1914</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS.                                |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE City MD.</b>                |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>LUTHERAN HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>GROOM</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>  |  |   | 13b. COUNTY<br><b>BALTO.</b>   |   | 13c. CITY OR TOWN<br><b>BALTO.</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>2309 CHELSEA TERR. 21216</b> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>TAYLOR HENRY FORD</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>EMMA UNKNOWN</b>  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |  |   | 16b. SOCIAL SECURITY NO.<br><b>121-16-6544</b>                         |   | 17. INFORMANT<br><b>YVONNE FORD</b>  |  | ADDRESS<br><b>2309 CHELSEA TERR. 21216</b>   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Septic shock.</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Pneumonia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Respiratory failure.</b> |  |   |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH           |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)           |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>11/10/84 19 84 to 11/6 19 84</b> |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/6 84</b> to <b>11/6 84</b> , that (I) (we) last saw the deceased alive on <b>11/6 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>BICH T DUONG</b>   |  |   |  |   | DEGREE<br><b>M.D.</b>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/6/84</b>                     |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BICH T DUONG</b>  |  |   |  |   | 22e. ADDRESS<br><b>LUTHERAN HOSPITAL</b>   |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  |   | 23b. DATE<br><b>11/10/84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WESTVIEW</b>                                    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>UPPERVILLE VA.</b>  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>ROYSTON FUNERAL HOME MARSHALL VA.</b>  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 7 1984</b>                                       |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |  |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 4 29811

FOR  
1- STATE  
REGISTRAR

|  |         |                              |   |  |   |   |  |                                   |
|--|---------|------------------------------|---|--|---|---|--|-----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                |         |                              | 2a. DATE KNOWN OF DEATH   |  |   | 2b. HOUR  |  |                                   |
| FIRST MIDDLE LAST<br>Josephine Foster                              |         |                              | MONTH DAY YEAR<br>11/17/ 1984   |  |   | 12:18 P M   |  |                                   |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH             | 6. AGE  | IF UNDER 1 YR.   | IF UNDER 24 HRS.  | 2c. DATE PRONOUNCED DEAD                                      |  |                                   |
| Female   | Black   | MONTH DAY YEAR<br>9-26-23    | YRS.<br>61  | MONTHS DAYS  | HOURS MIN.  | 11/17/ 1984   |  |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                          |         | 7b. CITIZEN OF WHAT COUNTRY? |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |  |                                   |
| MD.  |         | USA                          |   |  |   | Baltimore City, MD.   |  |                                   |
| 10. CITY OR TOWN OF DEATH  |         |                              | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |
| Baltimore  |         |                              | University Hospital   |  |   |   |  |                                   |
| 13a. STATE   |         |                              | 13b. COUNTY   | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS   |  |                                   |
| MD.  |         |                              |   | Balto.   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 1114 Harlem Ave. 21217  |  |                                   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST                             |         |                              |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |   |   |  |                                   |
| Hobert Madison   |         |                              |   | Mabel Madison  |   |   |  |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) |         |                              | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS   |   |  |                                   |
|  |         |                              | 218-18-6965   |  | Janet Madison 1627 N. Hilton St. (16                                |   |  |                                   |

|   |  |  |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY:   |  |  |
| IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u>                            |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. |  |  |
| (b) <u>DUE TO, OR AS A CONSEQUENCE OF</u>   |  |  |
| (c)   |  |  |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

|   |  |   |   |   |
|---|--|---|---|---|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |   | 20. AUTOPSY?  |
|   |  |   |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH             |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |

22a. I certify that I took charge of the remains described above, held on Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE Margaret A. Korell TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER DATE SIGNED 11/18/84

EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn St.

|   |           |                                    |  |        |       |
|---|-----------|------------------------------------|--|--------|-------|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN                               | COUNTY | STATE |
| Burial                                    | 11-21-84  | Mt. Auburn Cem.                    | Westport   |        | MD.   |
| 24. FUNERAL DIRECTOR NAME ADDRESS         |           |                                    | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE |        |       |
| Chas.A.Rice FSPA 1300 Eutaw Place         |           |                                    | NOV 26 1984 Julia Davidson-Randall                       |        |       |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 6 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25M

BP  
DHMH - 17  
(VR A15 ME (5))



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |                       |  |  |
|--|--|--|--|---|--|--|-----------------------|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   |  |  |                       |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>JEAN Baxter FOWLER   |  |  |  |   | 2a. DATE OF DEATH<br>11-21-84              |  | 2b. HOUR<br>3:30 A.M. |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>Sept. 19, 1889  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>95  |                       | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>CITY MD.   |                       |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Keswick |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Statistician   |                       | 12b. KIND OF BUSINESS OR INDUSTRY<br>Hospital  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                       | 13e. STREET ADDRESS / ZIP CODE<br>101 W. Monument St. 21201  |  |
| 14. FATHER'S NAME<br>Charles Johnstone Watson  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>Frances Wilson |  |                       |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220-30-2954   |  | 17. INFORMANT<br>Emmanuel Episcopal Church<br>Patricia Jones Cathedral & Read Sts.  |  |  |                       |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial Infarction<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASCVD with Angina<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |   |  |  |                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Instant<br>3 1/2 YRS   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |  |  |   |  |  |                       |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |                       |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |                       |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 21 Nov 84 to 21 Nov 84, that (I) (we) last saw the deceased alive on 21 Nov 84, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)   |  |  |  |   |  |  |                       |  |  |
| 22b. SIGNATURE<br>Aubrey D. Richardson M.D.  |  |  |  | DEGREE<br>M.D.  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                       | 22c. DATE SIGNED<br>21 Nov 1984  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Aubrey D. Richardson, M.D.  |  |  |  | 22e. ADDRESS<br>6500 York Rd.   |  |  |                       |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>Nov. 23, 1984   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arlington National  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Ft. Meyer Virginia   |                       |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212  |  |  |  | 25a. DATE RECEIVED BY FUNERAL DIRECTOR<br>NOV 30 1984   |  | 25b. RECEIVED BY REGISTRAR<br>NOV 30 1984  |                       |  |  |





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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |   |  | REG. NO. 29813 |  |
|---|--|--|--|---|--|--|--|---|--|----------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Tonia (Tonya) Fowlkes</b>   |  |  |  |   |  | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br><input checked="" type="checkbox"/> 11-20 1984              |  | 2b. HOUR<br>M<br>10:41 P. M.  |  |                |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 13 62</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>22 YRS.</b>  |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>11-20 1984</b>                     |  |                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>                                       |  |   |  |                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>800 blk. Rutland Avenue</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>          |  | 13e. STREET ADDRESS<br><b>1731 E. Ellsworth St. 21213</b>                           |  |                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Wilbert Fowlkes</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mildred Burch</b>   |  |  |  |   |  |                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>215-80-5881</b>  |  | 17. INFORMANT ADDRESS<br><b>Wilbert Fowlkes 3800 Cedar Dr,</b>   |  |   |  |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gunshot Wounds of Head (unspecified)</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH              |  |  |  |   |  |  |  |   |  |                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |  |  |   |  |  |  |   |  |                |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |  | 21b. TIME OF INJURY<br>HOUR MONTH DAY YEAR<br><b>approx. 10:34PM 11-20 19 84</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>subject was shot</b> |  |   |  |                |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>in auto</b>   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>800 blk. Rutland Avenue, Balto., Md.</b>         |  |   |  |                |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |  |   |  |  |  |   |  |                |  |
| ACTUAL SIGNATURE<br><i>Dennis F. Smyth</i>  |  |  |  | TITLE (SPECIFY)<br><b>Assistant</b>   |  |  |  | MEDICAL EXAMINER<br>DATE SIGNED <b>11-21-84</b>                                     |  |                |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Dennis F. Smyth, M.D.</b>  |  |  |  | ADDRESS<br><b>111 Penn St., Balto., Md. 21201</b>   |  |  |  |   |  |                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11/27/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD</b>  |  |   |  |                |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>   |  |  |  | ADDRESS<br><b>1101 E. North Ave.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 26 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>                         |  |                |  |

20% COTTON FIBER

WINTER 1940



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FOR  
1. STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 8 1 4

REG. NO.

|  |                  |   |  |   |   |
|--|------------------|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Anha E. Frazier   |                  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11-9-84  |  | 2b. HOUR<br>4:10 p.m.   |   |
| 3. SEX<br>Female   | 4. RACE<br>Black | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>07 13 04  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>UNKNOWN   |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Lutheran |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD   |   |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Domestic   |                  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Pvt. Family  |  |   |   |
| 13a. STATE<br>Maryland   |                  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Thomas H. Jones  |                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Cora Jackson   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No.  |                  | 16b. SOCIAL SECURITY NO.<br>213-20-9261A  |  | 17. INFORMANT<br>1111 Springfield Avenue<br>Baltimore, Maryland 21239   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Cardiogenic shock. Renal failure.</u> |                  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION<br>10-15-84   |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10-15</u> , 19 <u>84</u> , to <u>11-9</u> , 19 <u>84</u> , that (I) (we) lost<br>saw the deceased alive on <u>11-9</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |                  |   |  |   |   |
| 22b. SIGNATURE<br>Malks  |                  |   |  | 22c. DATE SIGNED<br>11-9-84   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>A. Mathew   |                  |   |  | 22e. ADDRESS<br>730 Ashborton St. - Lutheran Hospital<br>Baltimore  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |                  | 23b. DATE<br>11/14/1984   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Memorial Park   |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland  |                  | 24. Nutter & Sons F. 2501 Gwynns Falls Parkway<br>Home Inc. Baltimore, Maryland 21216                                 |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 13 1984  |   |
|  |                  |   |  | 25b. REGISTRAR'S SIGNATURE<br>Davidson-Randall  |   |

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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12/14/1964 Arctic Memorial Park

Belmont, Maryel M. 2121

Home Inc.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for an U.S. armed force, or other traumatic event, the medical examiner must be contacted at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 4 2 9 8 1 5<br>REG. NO.   |  |  |   |                         |
|---|--|--|--|---|--|--|---|-------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Rebecca Freedman</b>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>11 24 84</b>  |  |  |   | 2b. HOUR <b>2:58 PM</b> |
| 3. SEX <b>Female</b>  |  | 4. RACE <b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>12 25 1897</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS.   |   |                         |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>ENGLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.   |   |                         |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Levindale</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>HOMEMAKER</b>   |   |                         |
| 13a. STATE <b>MARYLAND</b>  |  |  |  | 13b. COUNTY <b>BALTIMORE</b>  |  | 13c. CITY OR TOWN <b>PIKESVILLE</b>  |   |                         |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>BENJAMIN GOLDSTEIN</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>ROSE COHEN</b>   |  |  |   |                         |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO. <b>219-42-5326A</b>   |  | 17. INFORMANT ADDRESS<br><b>RAYMOND ZILBER 3210 SHELBURNE RD. ( 21208)</b>  |  |  |   |                         |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>congestive heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>diabetes</b>                      |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>days</b><br><b>years</b> |                         |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b></b>  |  |  |  |   |  |  |   |                         |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |                         |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |  |   |                         |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |                         |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/24 1984</b> to <b>11/24 1984</b> , that (I) (we) last saw the deceased on <b>11/24 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |   |                         |
| 22b. SIGNATURE <b>S. Stevenson MD</b>   |  |  |  | 22c. ADDRESS <b>LEVINDALE GERIATRIC HOSPITAL BALTO, MD.</b>   |  | 22d. DATE SIGNED <b>11/24/84</b>   |   |                         |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE OR PRINT) <b>BURIAL</b>  |  | 23b. DATE <b>11/25/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>HEBREW YOUNG MENS CEM</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>BALTIMORE, BALTIMORE, MD.</b>  |   |                         |
| 24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS.</b><br><b>60110 REISTERSTOWN RD. BALTIMORE, MD. ( 21215)</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>NOV 28 1984</b>  |  |  |   |                         |
|   |  |  |  | 25b. REGISTRAR'S SIGNATURE <b>Gula Davidson-Randall</b>   |  |  |   |                         |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 8 1 6

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |  |   |   |                                       |  |   |   |   |                               |  |
|--|--|--|---|---|---------------------------------------|--|---|---|---|-------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Antoinette R Freze</i>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>11-12-84</i>                      |   | 2b. HOUR<br><i>8<sup>00</sup> A M</i> |  |   |   |   |                               |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>White</i>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>1-13-1914</i>  |                                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>70</i>   |   | 7. UNDER 1 YEAR<br>MONTHS DAYS<br><i>YRS</i>  |   | 8. UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Balto. Md.</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.  |   |   |   |                               |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Francis Scott Key Medical Center</i> |   |   |                                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Armco Steel</i>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Retired</i>   |   |                               |  |
| 13a. STATE<br><i>Md.</i>   |  |  | 13b. COUNTY<br><i>Balto.</i>  |   | 13c. CITY OR TOWN<br><i>Balto.</i>    |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br><i>4302 Greenhill Avenue</i>  |                               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Andrew Stefan</i>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Marianne Rzepkowski</i> |   |                                       |  |   |   |   |                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>  |  |  | 16b. SOCIAL SECURITY NO.<br><i>218-04-7401A</i>                             |   |                                       | 17. INFORMANT<br>ADDRESS<br><i>Santo J. Navarra - 14740 Old York Road<br/>Phoenix, Md. - 21131</i>   |   |   |   |                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. IMMEDIATE CAUSE (a) <i>Acute Cardiac Arrest</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Recurrent Ventricular Arrhythmia</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Arteriosclerotic Cardiovascular Disease</i><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><i>Chronic Bronchitis; Hypertension; Documented Cerebral Infarct</i> |  |  |   |   |                                       |  |   |   |   |                               |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                            |   |                                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |                               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                  |   |                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)   |   |   |   |                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)      |   |                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |   |                               |  |
| 22a. I certify that (I) ( <del>the hospital</del> ) attended the deceased from <i>2/4/81</i> 19 <i>81</i> , to <i>1/12/84</i> 19 <i>84</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>9/22/84</i> 19 <i>84</i> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) (did not) view the body after death.  |  |  |   |   |                                       |  |   |   |   |                               |  |
| 22b. SIGNATURE<br><i>Albin B. Bradley</i>  |  |  | DEGREE<br><i>MD</i>   |   |                                       | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   | 22c. DATE SIGNED<br><i>11/12/84</i>                             |                               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  | 22e. ADDRESS  |   |                                       |  |   |   |   |                               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Entombment</i>  |  |  | 23b. DATE<br><i>11-14-84</i>  |   |                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Gardens of Faith Cem.</i>   |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Balto. Md.</i> |                               |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>John C. Miller Inc-6415 Belair Rd.-21206</i>  |  |  |   |   |                                       | 25a. DATE REC'D. BY REGISTRAR<br><i>NOV 16 1984</i>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |   |                               |  |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11-12-70

James A. [unclear]

70

1-1-1-1

11

11

Baltimore City

11-1-1

11-1-1

James Scott [unclear] James Scott

11-1-1

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked optional item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 50M 4/83  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 84 29817  |  | REG. NO.  |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>HAROLD L. FRIEZE   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Nov 9 84   |  | 2b. HOUR<br>1201 M  |  |  |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>Caucasian  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>02 11 29  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>55 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South Balto. General Hosp. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired                     |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  | 13b. COUNTY<br>-  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>7905 TRAPPE Rod. 21222   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Chester Frieze  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Irene Ovalman  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>UNK   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212249782  |  | 17. INFORMANT<br>Chakt  |  | ADDRESS<br>3001 S. HANOVER STR.   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiorespiratory arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) LUNG CARCINOMA - oat cell<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:<br>COPD, Liver Metastasis of Lung CA, metastatic pleural effusion, (Radical metastasis)  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET<br>CITY OR TOWN<br>COUNTY<br>STATE  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from -10-29, 1984, to Nov. 9, 1984, that (I) (we) lost<br>saw the deceased alive on Nov. 9, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Lisa Mary Yatz / Dorothea Steen   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>11-9-84   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Ana M. Martinez / Dorothea Steen   |  |   |  | 22e. ADDRESS<br>3001 S. Hanover St. Balto, Md 21232   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>11/12/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Sacred Heart  |  | 23d. LOCATION<br>CITY OR TOWN<br>COUNTY<br>STATE<br>Baltimore, Md.                              |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Connelly Funeral Home of Dundalk  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 14 1984  |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randell  |  |  |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified on page 1.

FOR  
1 - STATE  
REGISTRAR

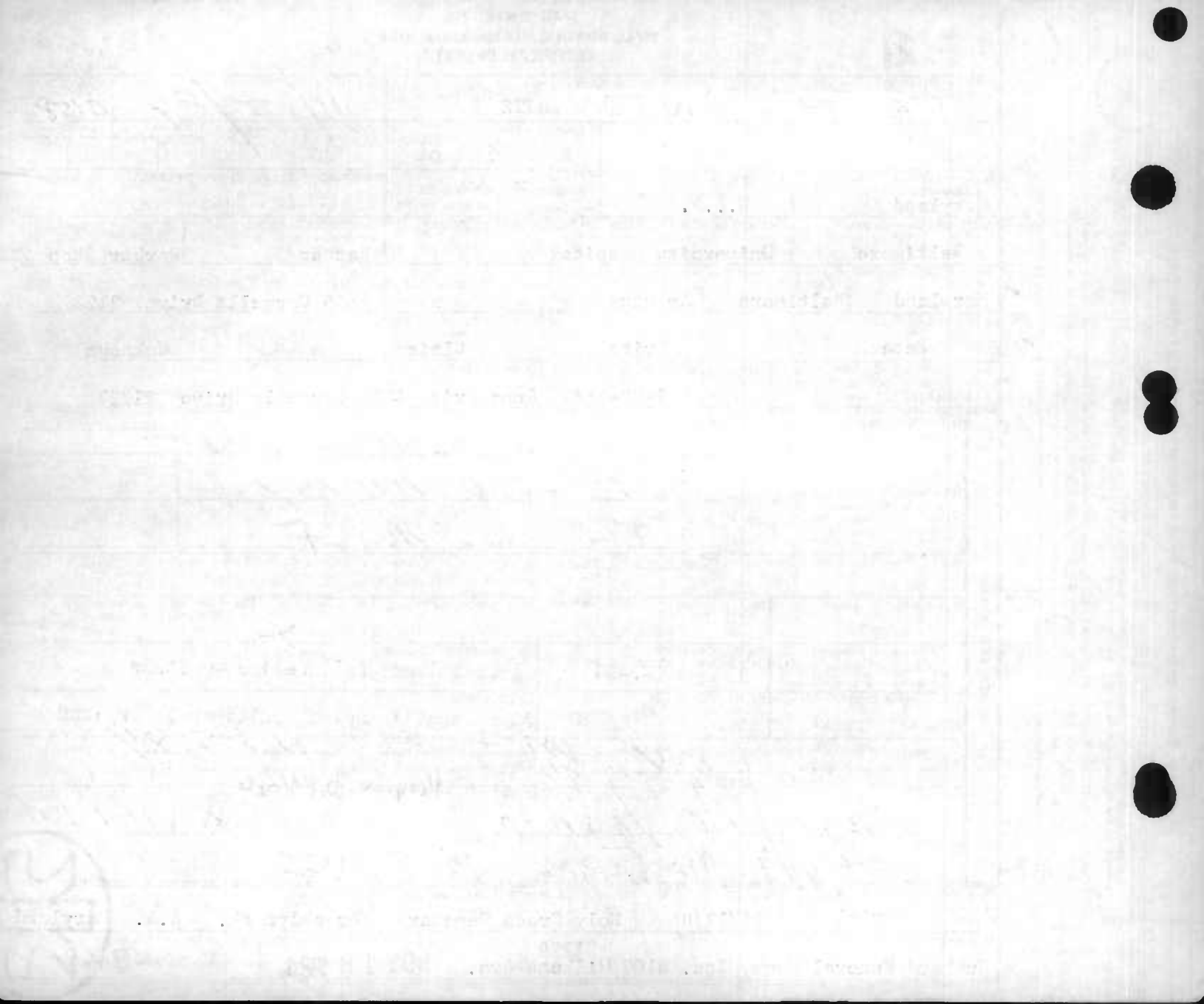
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 8 1 8

REG. NO.

|  |  |   |   |   |  |  |  |   |   |  |  |
|--|--|---|---|---|--|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ANTON FRITZ</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11/15/84</b>                                |   |  | 2b. HOUR<br><b>0158 PM</b>   |  |   |   |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 9 04</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b>   |  | 7. UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YES</b>   |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Barber</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Barber Shop</b>   |   |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   | 13a. STATE<br><b>Maryland</b>   |   |  | 13b. COUNTY<br><b>Baltimore</b>  |  |   | 13c. CITY OR TOWN<br><b>Arbutus</b>   |  |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   | 13e. STREET ADDRESS / ZIP CODE<br><b>4825 Carmella Drive 21227</b>                    |   |  |  |  |   |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Peter Fritz</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Clair Unknown</b>                 |   |  |  |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  |   | 16b. SOCIAL SECURITY NO.<br><b>219-22-2184</b>  |   |  | 17. INFORMANT<br>ADDRESS<br><b>Anna Fritz 4825 Carmella Drive 21227</b>  |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CLOSED HEAD INJURY</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ACUTE MYOCARDIAL INFARCTION</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b> |  |   |   |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                    |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                      |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR AM. MONTH DAY YEAR<br><b>11 AM 11-7-84 19</b>             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>loss balance fell fell down steps</b> |  |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>home</b> |   |  | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>4825 Carmella Drive Baltimore, Maryland</b>                               |  |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>NOV 7 1984</b> to <b>NOV 15 1984</b> , that (I) (we) lost saw the deceased <b>NO</b> above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |  |  |   | 22b. SIGNATURE<br><b>Larry J. MacFarlane</b>                                    |  |  |
| 22c. DATE SIGNED<br><b>11/15/84</b>  |  |   |   |   |  |  |  |   | 22d. ADDRESS<br><b>MIEHSS</b>   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>11/17/84</b>  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Cross Cemetery</b>   |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brooklyn Pk. A.A. Maryland</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Hubbard Funeral Home, Inc. 4107 Wilkens Ave.</b>  |  |   |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 16 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Lelia Davidson-Rendell</b>   |   |  |  |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 8 1 9

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |   |   |   |  |   |  |   |  |
|---|--|---|---|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>CHARLES EARL FULLER</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 17, 1984</b> |   |  | 2b. HOUR<br><b>8:55 AM</b>  |  |   |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JULY 14 1919</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b><br>YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTIMORE, MD.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>CHURCH HOSPITAL</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)<br><b>ACCOUNTANT</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>SOC. SECURITY</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |   |   |  |   |  |   |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br>-----  |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>520 S. BOND ST. 21231</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>RAYMOND FULLER</b>   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARIE HOLLAND</b>   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>216 16 2178</b>   |   | 17. INFORMANT ADDRESS<br><b>HANNAH HOLLAND 520 S. BOND ST. 21231</b>  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>RESPIRATORY FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>SEVERE <del>NO</del> CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b>   |  |   |   |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>CARDIOVASCULAR DISEASE<br/>RECURRENT SEPTICEMIA; LEFT PNEUMOTHORAX; ARTERIOSCLEROTIC</b>   |  |   |   |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>SEPTEMBER 13, 1984</u> , to <u>NOVEMBER 17, 1984</u> , that (I) <u>(we)</u> lost saw the deceased alive on <u>NOVEMBER 17, 1984</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> <u>(did)</u> <u>(did not)</u> view the body after death. |  |   |   |   |  |   |  |   |  |
| 22b. SIGNATURE<br><i>Chi Shiang Chen</i>  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |  |   |  | 22c. DATE SIGNED<br><b>NOVEMBER 17, 1984</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CHI SHIANG CHEN</b>   |  |   |   | 22e. ADDRESS<br><b>CHURCH HOSPITAL CORPORATION, *<br/>100 N. BROADWAY, BALTIMORE, MD 21231</b>  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>NOV. 20 1984</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>OAK LAWN CEMETERY</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MD.</b>                              |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>LITLY &amp; ZEILER, INC. 1901 EASTERN AVE. 21231</b>   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 20 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>John Davidson</i>  |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1- FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  | 84 29820<br>REG. NO.  |  |  |  |
|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>DORIS Doris - GABBERT   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>NOVEMBER 19 84 |   |  | 2b. HOUR<br>10:17AM   |  |  |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>12 19 11   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS.  |  | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>West Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD                                      |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Francis Scott Key Medical Center |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                      |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Newman Perkins   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Maggie Simmons  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>233-18-7606  |  | 17. INFORMANT ADDRESS<br>Dora Taylor (sister) Same as 13  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cerebral Vascular Accident<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>DIABETES MELLITUS   |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br>-   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>-  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><input type="checkbox"/>  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br>-   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>-   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br>-   |  |   |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from NOVEMBER 19 84, to JUDITH, that (I) (we) lost saw the deceased alive on NOVEMBER 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Roman A. Goy MD   |  |  |  | DEGREE<br>MD  |  |   |  | 22c. DATE SIGNED<br>NOV 19, 84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ROMAN A. GOY MD  |  |  |  | 22e. ADDRESS<br>FRANCIS SCOTT KEY MED CTR   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>Nov. 23, 1984   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Morningside Cemetery  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Renick, West Virginia                                |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Capitol Funeral Service, Falls Church, VA  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 23 1984  |  | 25b. REGISTRAR'S SIGNATURE<br>Jia Linder-Randall  |  |  |  |

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202 85 404

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 8 2 2

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |   |  |  |   |
|---|--|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MICHAEL GALAYDA</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 4, 1984</b>                         |  | 2b. HOUR<br><b>09:30pm</b>                                      |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 4, 1911</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Penna.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                      |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(1) HOME WORK (2) MOST OF WORKING LIFE<br><b>Miner (bet.)</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Coal Indust.</b>        |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Penna.</b> |  |   | 13b. COUNTY<br><b>Cambria</b>  |  |   |
| 13c. CITY OR TOWN<br><b>Johnstown</b>   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |
| 13e. STREET ADDRESS / ZIP CODE<br><b>R.D. # 2 15902 99999</b>   |  |   |  |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Wasil Galayda</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Bertha Danasko</b>  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>N/A</b>   |  | 17. INFORMANT (daughter) ADDRESS<br><b>Mrs. Margaret Webb Johnstown, Pa. 15904</b> |   |

18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c))  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Respiratory Failure**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b) **PNEUMONIA**

DUE TO, OR AS A CONSEQUENCE OF

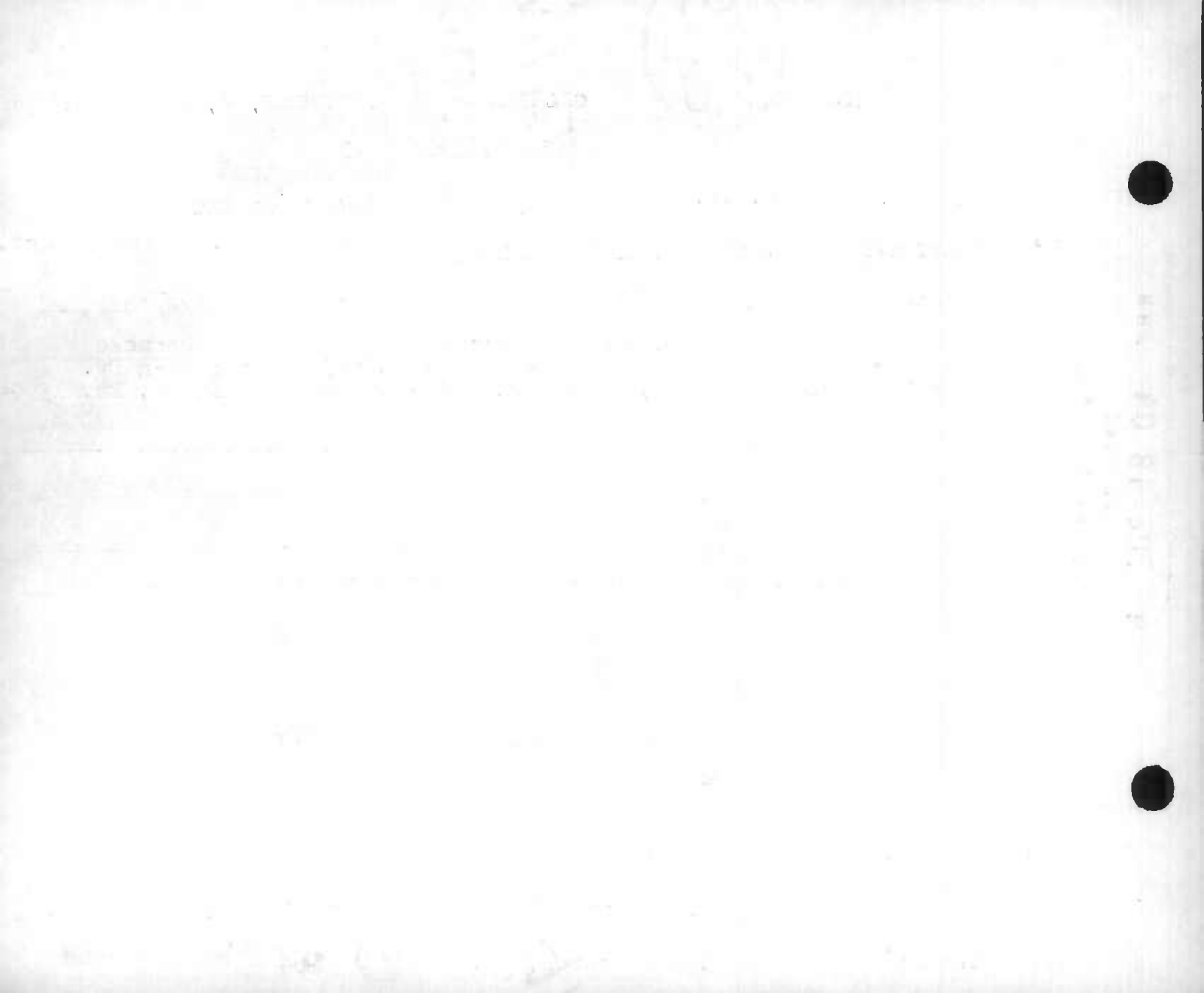
(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**5 DAYS****5 DAYS**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 1a:

**Right Lung SQUAMOUS CELL CANCER Chronic obstructive Pulmonary Disease**

|   |  |  |   |
|---|--|--|---|
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |
| 21d. INJURY OCCURRED<br>AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/31</b> , 19 <b>84</b> , to <b>11/4</b> , 19 <b>84</b> , that (I) (we) last<br>saw the deceased alive on <b>11/4</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |   |
| 22b. SIGNATURE<br><b>Brenda C. McClain, M.D.</b>  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED<br><b>11/4/84</b>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Brenda C. McClain, M.D.</b>   |  | 22e. ADDRESS<br><b>The Johns Hopkins Hospital</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>11/8/1984</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Grandview Cemetery</b>  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Johnstown Cambria Pa.</b>  |
| 24. FUNERAL DIRECTOR<br>NAME <b>E. Barnes</b> ADDRESS<br><b>Fleming Funeral Service - Benson, Md.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 9 1984</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMM - 16 50M 4/82  
(VRA 15, 4)FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 8 2 3

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Valjean Gambill</b>                      |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 4, 1984</b>                             |   |  | 2b. HOUR<br><b>P</b><br>M  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>September 28, 1921</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> YRS                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Oklahoma</b>                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                      |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1544 Wadsworth Way (Residence)</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Health Dept</b> |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Baltimore Co</b>                           |  |  |  |   |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>                              |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Gambill</b>                      |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Helen ? ?</b>                          |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b> |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>1941 To 1964 462-10-3816</b> |   | 17. INFORMANT<br>ADDRESS<br><b>Geraldine M Gambill Same As 13e</b> |  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1: DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) cardiorespiratory arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b) probable pulmonary embolism / ankylosis

DUE TO, OR AS A CONSEQUENCE OF

(c) lung cancerAPPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from <u>10/22</u> , 19 <u>84</u> , to <u>11/3</u> , 19 <u>84</u> , that (we) lost saw the deceased alive on <u>11/3/84</u> , 19 <u>84</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><i>[Signature]</i>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/5/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. William M. Parham M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>3100 Wyman Park Drive Baltimore, Maryland</b>   |  |  |  |

|   |  |                             |  |   |  |  |  |
|---|--|-----------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b> |  | 23b. DATE<br><b>11/8/84</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Forest Va</b> |  | 23d. LOCATION<br>(CITY OR TOWN) COUNTY STATE<br><b>Baltimore, Maryland</b> |  |
|---|--|-----------------------------|--|---|--|--|--|

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck, Inc. Baltimore, Maryland</b> |  | 25. DATE RECD. BY REGISTRAR<br><b>NOV 7 1984</b> |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i> |  |
|--|--|--|--|--|--|



Handwritten notes and symbols, including the word 'OCT' and various scribbles.



Dr. [illegible] [illegible]  
[illegible] [illegible] [illegible]  
[illegible] [illegible] [illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |  |   |  |   |  |   |
|--|--|--|---|--|---|--|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>NORMAN LEROY GAINES</b>   |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 16, 84</b> |  | 2b. HOUR<br><b>7:45a M</b>  |  |   |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6-1-29</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>55</b> YRS.                                    |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>7:45a M</b>  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>                    |   |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VA MEDICAL CENTER BALTIMORE MD</b> |   |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD.</b>   |  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Balto.</b>                            |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>? ? ?</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Carry Gaines</b>        |  |   | 13e. STREET ADDRESS / ZIP CODE<br><b>823 W. Fayette St. 21201</b>                    |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>6-51-5-53</b> |  | 17. INFORMANT<br>ADDRESS<br><b>2023</b>                       |  | 17. INFORMANT<br>ADDRESS<br><b>Archie R. Smothers Wheeler Ave. (16)</b>                         |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Fibrinous Pericarditis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Diabetes Mellitus, Renal Failure</b>   |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.0<br><b>Diabetes Mellitus, Renal Failure</b>   |  |  |   |  |   |  |   |  |   |
| 19a. DATE OF OPERATION<br><b>—</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>   |   |  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>— — — 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br><b>—</b>  |   |  |   |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>3900 Loch Raven Blvd. Baltimore, MD 21218</b>  |   |  |   |  |   |
| 22a. I certify that (X) (this hospital) attended the deceased from <b>Nov. 8,</b> 19 <b>84</b> , to <b>Nov. 16</b> , 19 <b>84</b> , that (X) (we) last saw the deceased alive on <b>Nov. 16</b> , 19 <b>84</b> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. |  |  |   |  |   |  |   |  |   |
| 22b. SIGNATURE<br><b>Akshay M. Amin MD</b>   |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   |  |   | 22c. DATE SIGNED<br><b>4/17/84</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Akshay M. Amin</b>   |  |  |   | 22e. ADDRESS<br><b>3900 Loch Raven Blvd. Baltimore, MD 21218</b>   |   |  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11-21-84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md. Vet. Cem.</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Crownsville MD.</b>                 |   | 23e. DATE REC'D BY REGISTRAR   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Chas.A. Rice FSPA 1300 Eutaw Place</b>  |  |  |   | 24. FUNERAL DIRECTOR<br>ADDRESS<br><b>1300 Eutaw Place</b>   |   | 25a. DATE REC'D BY REGISTRAR<br><b>NOV 26 1984</b>                                   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |   |

BP

X

11/11/74 10:00 AM 10:00 AM 10:00 AM 10:00 AM

— — — — —

ASST. S. V. J.

18-22a 1/14/85 mtb F#599

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- STATE  
REGISTRAR1. DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

ANGELINE

GARDNER

2a. DATE KNOWN OF  
DEATH ESTI-  
MATED ☒ 11-3-84 192b. HOUR  
M

3. SEX

4. RACE

5. DATE OF BIRTH

6. AGE (IN YEARS)

IF UNDER 1 YR.

IF UNDER 24 HRS.

2c. DATE

MONTH DAY YEAR

2d. HOUR

Female

Black

12 29 52

31 YRS.

MONTHS DAYS HOURS MIN.

2e. DATE

MONTH DAY YEAR

2f. HOUR

7a. BIRTHPLACE (STATE OR  
FOREIGN COUNTRY)

7b. CITIZEN OF WHAT COUNTRY?

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Balto. Md.

USA

Baltimore City MD.

10. CITY OR TOWN OF DEATH

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

12a. USUAL OCCUPATION (TYPE OF WORK  
FOR MOST OF WORKING LIFE)12b. KIND OF BUSINESS  
OR INDUSTRY

Baltimore

2430 St. Paul St. 2nd Floor

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

13b. COUNTY

13c. CITY OR TOWN

13d. INSIDE CITY LIMITS?

13e. STREET ADDRESS

Md.

Balto.

YES ☒ NO ☐

2430 St Paul St. 2nd Fl.

14. FATHER'S NAME

FIRST

MIDDLE

LAST

15. MOTHER'S MAIDEN NAME

FIRST

MIDDLE

LAST

Willie

Gardner

Augustine

Moore

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO, OR UNKNOWN)

16b. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

No

219-16-5783

Evelyn Roscoe 918 Seagull Ave. 21225

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Phenothiazine Overdose

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a) stating the under-  
lying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☒ OR  
CONTRIBUTING ☐ CAUSE OF DEATH21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
12:40 P.M. 11/3 84

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

subject ingested drug

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☒  
AT WORK AT WORK21e. PLACE OF INJURY (AT HOME,  
STREET, FACTORY, FARM, ETC.)

home

21f. LOCATION

2430 St. Paul St. CITY OR TOWN, COUNTY STATE

22a. I certify that I took charge of the remains described above, held on

Autopsy ☒Inspection ☐Inquiry ☐

and in my opinion

death resulted from: Natural causes ☐Accident ☐Suicide ☐Homicide ☐Undetermined manner ☒ACTUAL  
SIGNATURE

TITLE (SPECIFY)

M.D. Assistant MEDICAL EXAMINER

DATE

SIGNED 11-4-84

EXAMINER'S NAME  
(TYPE OR PRINT)

Gregory R. Kauffman, M.D.

ADDRESS 111 Penn Street

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION

CITY OR TOWN

COUNTY STATE

Burial

11/8/84

Eastview Mem. Cem.

Balto. Md.

24. FUNERAL DIRECTOR

ADDRESS

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

Wm. C. March F/H 1101 E. North Ave.

NOV 7 1984

Kia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE  
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.  
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES.  
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS  
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST.,  
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.07/84  
25MDHMH - 17  
(VR A15 ME (5))

20% COTTON FIBER

NEW YORK



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 50M 4/83  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |   |  | REG. NO. 8 4 2 9 8 2 5   |  |
|---|--|---|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME<br>FIRST MIDDLE LAST<br>George W. Gardner  |  | 2b. DATE OF DEATH<br>MONTH DAY YEAR<br>11 4 84  |  | 2c. HOUR<br>12 <sup>45</sup> A.M.   |  |   |  |  |  |
| 3. SEX<br>M   |  | 4. RACE<br>B  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 22 21   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>63 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS   |  | 7. IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Univ. of Md. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired                     |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |  |   |  |   |  |  |  |
| 13a. STATE<br>MARYLAND  |  | 13b. COUNTY<br>BALTIMORE  |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>100 MT. OLIVET LANE 21229                         |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>THOMAS GARDNER  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>IDA TALIFERO   |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES   |  |   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>223-24-2945  |  | 17. INFORMANT<br>ADDRESS<br>Bertha Gardner 100 Mt. Olivet La.                                   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CANDIDIAL SEPSIS<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) MULTIPLE MYELOMA<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) RENAL FAILURE<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 mos |  |   |  |   |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>HYPERCALCEMIA 8/30/84   |  |   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 19c. AUTOPSY<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 1 <sup>st</sup> Sept 1984, to November 4 1984, that (I) (we) last saw the deceased alive on November 4 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |   |  |  |  |
| 22a. SIGNATURE<br>Angela Corbin, MD   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br>11/4/84   |  |  |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ANGELA CORBIN  |  |   |  | 22e. ADDRESS<br>UNIVERSITY OF MARYLAND  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>11/8/84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Nat'l   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY<br>Baltimore MD  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H 1101 E. North Ave.   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 5 1984   |  | 25b. REGISTRAR'S SIGNATURE<br>W. C. Davidson-Randall                                |  |  |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified of a possible homicide.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 4 2 9 8 2 6   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | CERTIFICATE OF DEATH  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  | 2a. DATE OF DEATH   |  |  |  |
| FIRST MIDDLE LAST<br>Rachel E. Gardner  |  |  |  | MONTH DAY YEAR<br>Nov. 22, 1984   |  |  |  |
| 3. SEX<br>F.  |  | 4. RACE<br>W.  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>April 16, 1906  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2428 E. FAYETTE ST |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>CLERK  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>CANDY STORE   |  |
| 13a. STATE<br>MD  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>? ? ?   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Margaret Della  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>212-14-0786  |  |
| 17. INFORMANT<br>John Wilinski  |  | ADDRESS<br>3625 Elmley Ave   |  | 21213   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIO-VASC DLS.<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5 yrs |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/24 19 84, to 11/22 19 84, that (I) (we) last saw the deceased alive on 9/24 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>Irwin B. Kaplan MD  |  |  |  | DEGREE  |  | 22c. DATE SIGNED<br>11/23/84   |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br>IRWIN B. KAPLAN MD   |  |  |  | 22e. ADDRESS<br>129 S. BROADWAY BALTO 21231   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>Nov. 26, 1984   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>PARKWOOD CEM.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MD   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>HARTLEY MILLER  |  |  |  | ADDRESS<br>7527 HARFORD RD.   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 23 1984   |  |
|   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |  |  |  |

BP



3

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 8 2 7

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |   |
|---|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Martha F Gaines</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11/30/84</b>                               |   | 2b. HOUR<br><b>6:00 AM</b>  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>Black</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8/1/96</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b>  |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>City</b>   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University of Maryland</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>housewife</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br><b>MD</b>   |  |   | 13b. COUNTY<br><b>Balt. City</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Lewis N Williams</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lydia Williams</b>               |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>218-28-3350</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Delores Cromastie 2416 Edmondson Ave</b>                     |   |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio pulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Pneumonia</b>  |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>1</b>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a  |  |   |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>11/20 1984</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)              |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>22 S. Green St. Warrentown N.C.</b> |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/20 1984</b> to <b>11/30 1984</b> , that (I) (we) last saw the deceased alive on <b>11/29/84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |   |
| 22b. SIGNATURE<br><b>Guy Fromell MD</b>   |  |   |  | 22c. DATE SIGNED<br><b>11/30/84</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Guy Fromell</b>   |  |   |  | 22e. ADDRESS<br><b>22 S. Green St.</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>12-5-84</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Coley Spring Cem.</b>                       |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Warrentown N.C.</b>  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Chas. A. Rice FSPA 1300 Eutam Pl.</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 6 1984</b>  |   |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>                                  |   |

35  
38  
35  
320  
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MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

938111 NOV 1954

11/17/54

2110 Edmonstone  
W. H. Lewis

11/17/54

McIntire F

Female Black 8 1 10  
X

2110 Edmonstone X

Lewis H. Williams

2110 Edmonstone  
X

2110 Edmonstone  
X

TO RETAINED BY HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 8 2 8

REG. NO.

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Serena m. Gattis</b>  |  | 20. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 26 84</b>   |  | 2b. HOUR<br><b>12<sup>24</sup> A M</b>  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 25 02</b>   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.<br>IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Mercy Hospital</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Sandford Maddox</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lucinda Dorsey</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>N/A</b>   |  | 17. INFORMANT ADDRESS<br><b>Juanita Gattis 708 Springfield Ave.</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Respiratory Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Kidney Failure</b> |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                  |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>11-1</b> 19 <b>84</b> , to <b>11-26</b> 19 <b>84</b> , that (1) (we) last saw the deceased alive on <b>11-26</b> 19 <b>84</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Richard L. Linticum MD</b> DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>  |  |  |  | 22c. DATE SIGNED<br><b>11-26-84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RICHARD L. LINTICUM MD</b>  |  |  |  | 22e. ADDRESS<br><b>Mercy Hospital</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11/29/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. pk</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>   |  | 24b. ADDRESS<br><b>1101 E. North Ave.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co. MD</b>   |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 28 1984</b>   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |



CHIEF MAN

90% COTTON



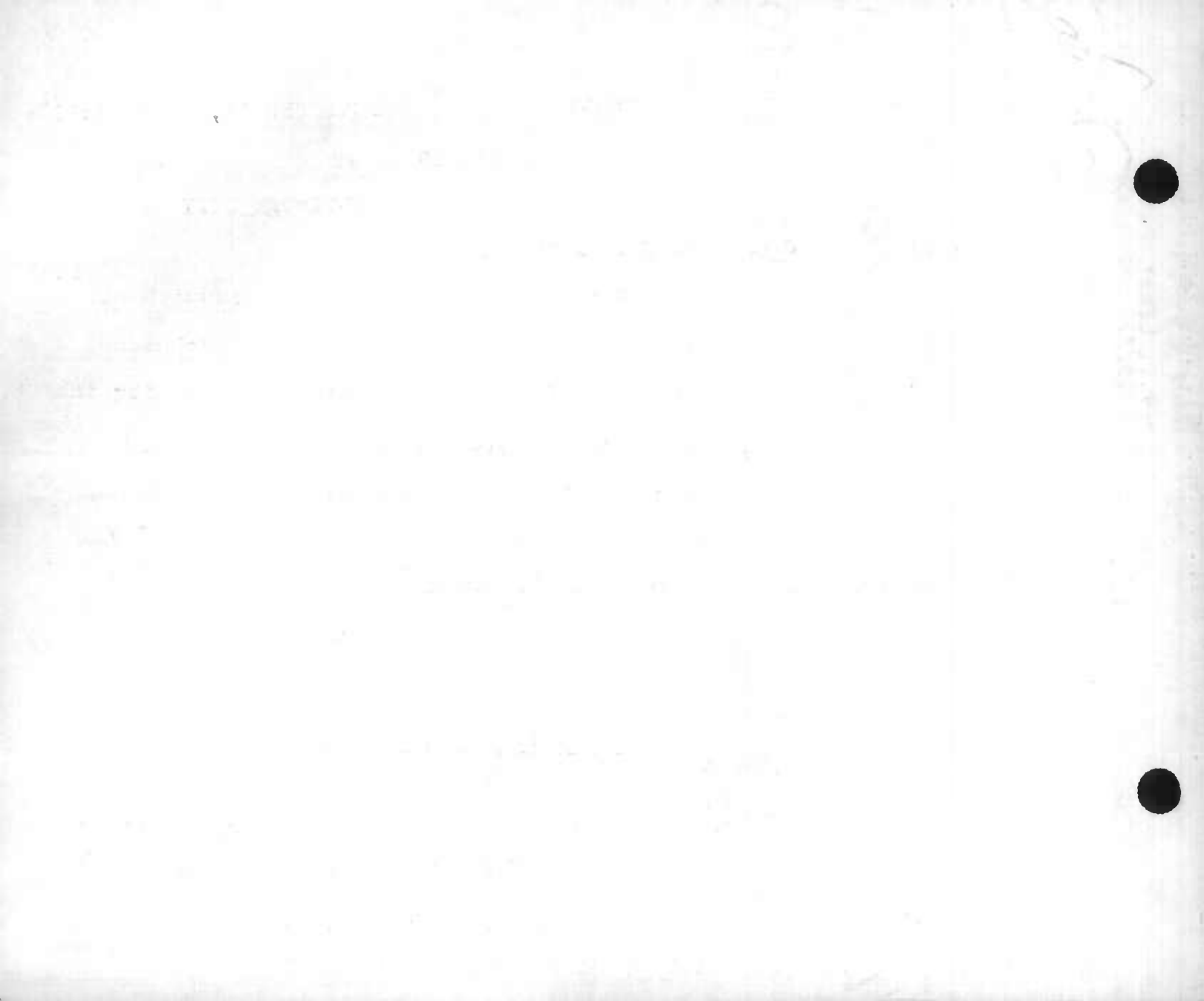
DHMH - 16 50M 4/83  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: This certificate may be retained by the hospital or attending physician for 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the local health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 4 2 9 8 2 9  |  |
|---|--|---|--|--|--|
| 1. STATE REGISTRAR  |  |   |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>LEROY GAULT SR.</b>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>NOVEMBER 21, 1984</b> |  | 2b. HOUR<br><b>5:21<sup>AM</sup></b>   |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>Black</b>                    | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>6 23 35</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br><b>49 YRS.</b>                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b>                     |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>21202</b>                |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Baltimore</b>                        | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Edward Gault</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Pattie Johnson</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>216-28-5205</b>  |  | 17. INFORMANT ADDRESS<br><b>Felicia A. Gault 1504 N. Aisquith St.</b>                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiovascular collapse</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Adult respiratory distress syndrome</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute renal failure</u>   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>10 min</u><br><u>10 days</u><br><u>5 days</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:<br><u>Cryptococcal meningitis, IV drug abuse</u>   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19<br><b>1984</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)               |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 30</u> 19 <u>84</u> , to <u>Nov 21</u> 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>Nov 21</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Daniel Ford</u>  |  | DEGREE<br><u>MD</u>   |  | 22c. DATE SIGNED<br><u>11/21/84</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DANIEL FORD</b>   |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital Baltimore MD</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11/26/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Memorial Pk.</b>                               |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Wm. C. March F/H</b>  |  | ADDRESS<br><b>1101 E. North Ave.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 23 1984</b>  |  |
| 23d. LOCATION CITY OR TOWN<br><b>Baltimore</b>  |  | COUNTY<br><b>Co.</b>  |  | STATE<br><b>MD</b>   |  |





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4  
25MBP  
DHMH - 17  
(VR A15 ME (5))

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                         |  |  |  |  |  |  |  |   |  | REG. 29830  |  |
|---|--|-------------------------|--|--|--|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Maxine Geerse</b>   |  |                         |  |  |  | 2a. DATE KNOWN OF DEATH<br><input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>11-23 1984</b> |  |  |  | 2b. HOUR<br><b>12:10</b>                      |  |   |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>BLACK</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11-26-46</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>37 YRS.</b>  |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |  | 7c. DATE PRONOUNCED DEAD<br><b>11-23 1984</b> |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTO</b>   |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>UNITED STATES</b>   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital - STU</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>  |  |   |  |   |  |
| 13a. STATE<br><b>MD.</b>  |  |                         |  | 13b. COUNTY<br><b>BALTO</b>  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Harry James Frink</b>  |  |                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Hazel Trueheart</b>  |  |  |  | 13e. STREET ADDRESS<br><b>21223</b>  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |  |                         |  | 16b. SOCIAL SECURITY NO.   |  |  |  | 17. INFORMANT ADDRESS<br><b>Genevieve Clayborne 2816 Oakley ave</b>  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Smoke Inhalation with complications</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause last.   |  |                         |  |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |  |                         |  |  |  |  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br><b>6:52 PM 11-22 1984</b>   |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>subject recovered from house fire</b>  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK <b>XX</b>  |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>Home</b>   |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>1724 W. Fayette St., Balto., Maryland</b>  |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                         |  |  |  |  |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE<br><i>Dennis F. Smyth</i>  |  |                         |  |  |  | TITLE (SPECIFY)<br><b>Assistant MEDICAL EXAMINER</b>   |  |  |  |   |  | DATE SIGNED<br><b>11-24-84</b>  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Dennis F. Smyth, M.D.</b>  |  |                         |  |  |  | ADDRESS<br><b>111 Penn St., Balto., Md. 21201</b>  |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  |                         |  | 23b. DATE<br><b>11-27-84</b>   |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Calvary Cem.</b>  |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. MD.</b>                     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Brown/Thompson FH</b>  |  |                         |  |  |  | ADDRESS<br><b>1913 W Baltimore St.</b>   |  |  |  |   |  | 25a. DATE REC'D BY REGISTRAR<br><b>NOV 30 1984</b>                                  |  |
|   |  |                         |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Jane Davidson-Randall</i>   |  |  |  |   |  |   |  |



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#5,6, FilmG597 11/27/84 kam

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 8 3 1

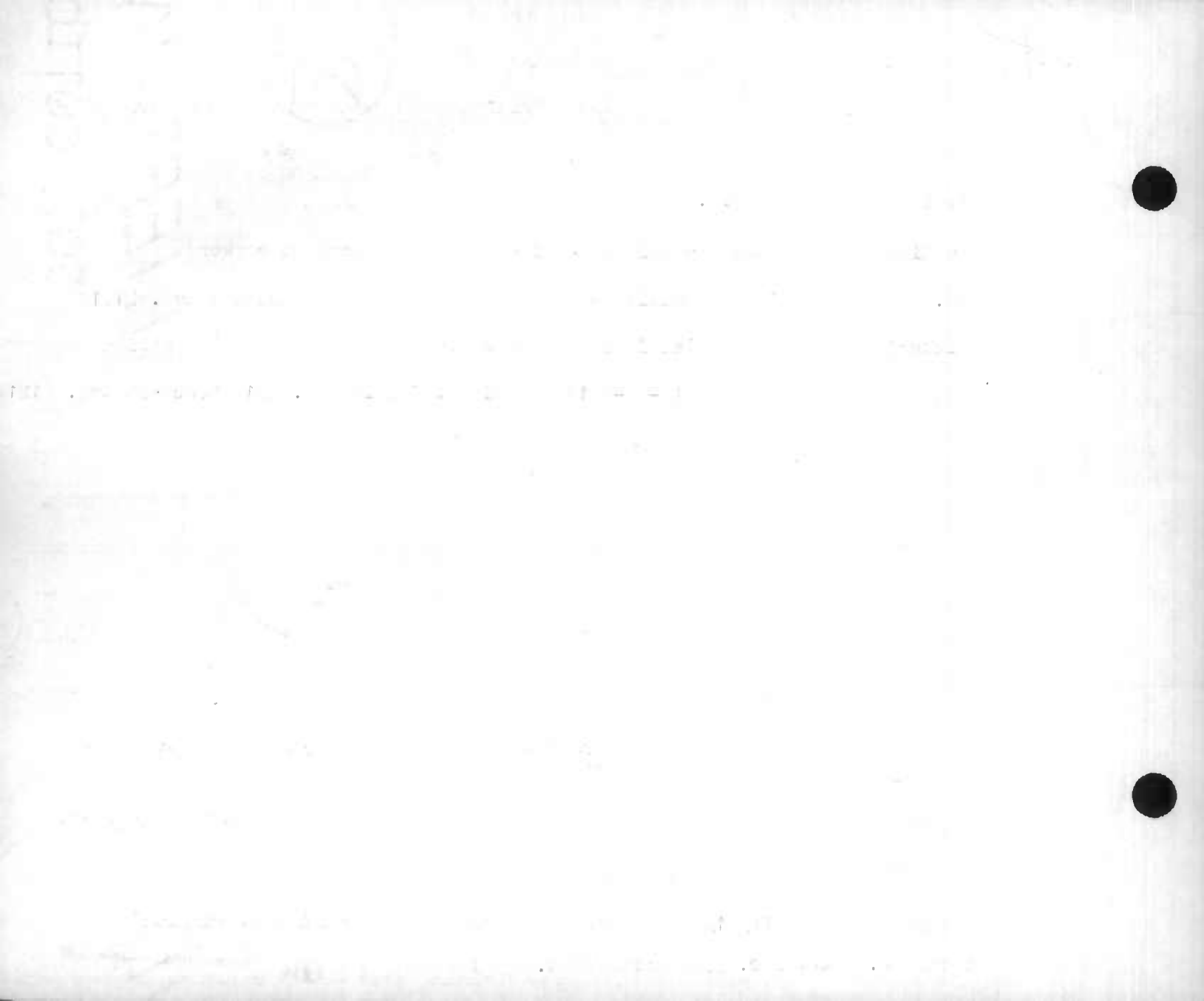
1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |  |  |
|--|--|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>LUCY GENTILE</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 18 1984</b>           |   | 2b. HOUR<br><b>11 P M</b>                    |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 13 1903</b>                                   |  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.  |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Italy</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>  |  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>   |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Good Samaritan Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>garment worker</b> |  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |   |  |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>3325 Reuckert Ave. 21214</b>   |  |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Michael Palmieri</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Concetta Rabbila</b> |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>212-24-8014</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Louis J. Gentile Sr. 3310 Reuckert Ave. 21214</b>          |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.          |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (b).   |  |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |  |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)             |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |
| 22a. I certify that (this hospital) attended the deceased from <b>11/16</b> , 19 <b>84</b> , to <b>11/18</b> , 19 <b>84</b> , that (we) lost<br>saw the deceased alive on <b>11/18</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (he) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |
| 22b. SIGNATURE<br><b>Thomas S. Miller</b>  |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>11/18/84</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>THOMAS S. MILLER</b>   |  | 22e. ADDRESS<br><b>GSH</b>  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11/21/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer</b>                                |  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |  |   |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck, Inc. 5305 Harford Rd.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>2/2/84</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson</b>  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Properly filled out, this certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |   |  |  |  |   |  | 8   | 4 | 2                                   | 9 | 8                           | 3 | 2 |
|--|--|--|--|---|--|--|--|---|--|---|---|-------------------------------------|---|-----------------------------|---|---|
| 1 - STATE REGISTRAR  |  |  |  |   |  |  |  |   |  | REG. NO.  |   |                                     |   |                             |   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>BESSIE GENTRY</b>   |  |  |  |   |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>20</b> YEAR <b>84</b>   |   |                                     |   | 2b. HOUR<br><b>110 A.M.</b> |   |   |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>BLACK</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>9</b> DAY <b>8</b> YEAR <b>96</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>  |  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b>  |   |                                     |   |                             |   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |  |   |  |   |   |                                     |   |                             |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |   |                                     |   |                             |   |   |
| 13a. STATE<br><b>MD</b>  |  |  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |  | 13e. STREET ADDRESS<br><b>2931 OAKLEY AVE</b> <b>21215</b>  |   |                                     |   |                             |   |   |
| 14. FATHER'S NAME<br>FIRST <b>300</b> MIDDLE <b>300</b> LAST <b>300</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>300</b> MIDDLE <b>300</b> LAST <b>300</b>  |  |  |  |   |  |   |   |                                     |   |                             |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>213-34-0840</b>  |  | 17. INFORMANT ADDRESS  |  |   |  |   |   |                                     |   |                             |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Gram negative sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Pneumonia, Urinary Tract Infection</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>SIP MI, CHF</b> |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |   |                                     |   |                             |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |   |                                     |   |                             |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)  |  |  |  |   |  |   |   |                                     |   |                             |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |   |   |                                     |   |                             |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-18</b> , 19 <b>84</b> , to <b>11-20</b> , 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>11-20</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |   |  | 22b. SIGNATURE<br><b>Roberta Tabaka</b> DO ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>11-20-84</b> |   |                             |   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROBERTA TABAKA</b>   |  |  |  | 22e. ADDRESS<br><b>9246 RED CART CT, Columbia, MD</b>   |  |  |  |   |  |   |   |                                     |   |                             |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11/24/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |  |  | 23d. LOCATION<br>CITY OR TOWN <b>Essex Co. Va.</b> COUNTY STATE   |  |   |   |                                     |   |                             |   |   |
| 24. FUNERAL DIRECTOR<br><b>C. Wainwright 2700 E DMONDSON AVE.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 23 1984</b>   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Lia Davidson-Rendell</i>   |  |   |   |                                     |   |                             |   |   |

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THE  
NATIONAL  
ARCHIVE

NO. 100

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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 STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |                              |                  |  |                |                  |   |  |  |
|--|------------------------------|------------------|--|----------------|------------------|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |                              |                  | 2a. DATE KNOWN OF DEATH  |                |                  | 2b. HOUR  |  |  |
| JAMES RICHARD GENTRY JR.   |                              |                  | 11 23 1984   |                |                  | 2:42 a.m.   |  |  |
| 3. SEX   | 4. RACE                      | 5. DATE OF BIRTH | 6. AGE (IN YEARS)  | IF UNDER 1 YR. | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD  |  |  |
| MALE   | WHITE                        | 03 02 32         | 52 YRS.  |                |                  | 11 23 1984  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY? |                  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                |                  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |  |
| MARYLAND   | U.S.A.                       |                  |  |                |                  | Baltimore City MD.  |  |  |
| 11. CITY OR TOWN OF DEATH  |                              |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |                |                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  |  |
| Baltimore  |                              |                  | St. Agnes Hospital (DOA)   |                |                  | PACKER  |  |  |
| 13a. STATE   |                              |                  | 13b. CITY OR TOWN  |                |                  | 13c. STREET ADDRESS   |  |  |
| MARYLAND   |                              |                  | BALTIMORE  |                |                  | 4455 FENOR ROAD, 21227  |  |  |
| 14. FATHER'S NAME  |                              |                  | 15. MOTHER'S MAIDEN NAME   |                |                  | 16. SOCIAL SECURITY NO.   |  |  |
| JAMES RICHARD GENTRY SR.   |                              |                  | DOROTHY CATHERINE SWANN  |                |                  | 215-28-7326   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |                              |                  | 16b. SOCIAL SECURITY NO.   |                |                  | 17. INFORMANT ADDRESS   |  |  |
| YES  |                              |                  | KOREAN   |                |                  | LOIS K. LEGG 513 KINTOP ROAD, 21061   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |                              |                  |  |                |                  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                              |                  |  |                |                  |   |  |  |
| 19a. DATE OF OPERATION   |                              |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                |                  | 20. AUTOPSY?  |  |  |
|  |                              |                  |  |                |                  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                              |                  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |                |                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |
|  |                              |                  | P.M. 19  |                |                  |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                              |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |                |                  | 21f. LOCATION   |  |  |
|  |                              |                  |  |                |                  | CITY OR TOWN COUNTY STATE   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                              |                  |  |                |                  |   |  |  |
| ACTUAL SIGNATURE   |                              |                  | TITLE (SPECIFY)  |                |                  | DATE SIGNED   |  |  |
|  |                              |                  | M.D. Assistant   |                |                  | 11-23-84  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |                              |                  | ADDRESS  |                |                  |   |  |  |
| Ann M. Dixon, M.D.   |                              |                  | 111 Penn St., Balto., Md. 21201  |                |                  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |                              |                  | 23b. DATE  |                |                  | 23c. NAME OF CEMETERY OR CREMATORY  |  |  |
| BURIAL   |                              |                  | 11-26-84   |                |                  | GLEN HAVEN MEM. PARK  |  |  |
| 24. FUNERAL DIRECTOR NAME  |                              |                  | 25a. DATE REC'D. BY REGISTRAR  |                |                  | 25b. REGISTRAR'S SIGNATURE  |  |  |
| HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.   |                              |                  | NOV 26 1984  |                |                  |   |  |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. This permit requires removal of the body from the place of death within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of such.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 8 3 4

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>RICHARD F Geoghegan</i>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>11 24 84</i> |   |  | 2b. HOUR<br><i>7:46 A.M.</i>  |  |
| 3. SEX<br><i>M</i>   |  | 4. RACE<br><i>E W</i>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>May 29, 1923</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>61</i> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Mercy Hospital</i> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Surveyor</i>             |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Construction</i>   |  |  |  |   |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>Maryland</i>  |  | 13b. COUNTY<br><i>Baltimore</i>  |  | 13c. CITY OR TOWN<br><i>Reisterstown</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 13e. STREET ADDRESS<br><i>11109 Thompson Ave.</i>  |  | 13f. ZIP CODE<br><i>21136</i>  |  |   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Floyd Geoghegan</i>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Ruth Watson</i>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>Yes</i>   |  | 16b. SOCIAL SECURITY NO.<br><i>W.W.II 216-16-9143</i>  |  | 17. INFORMANT<br><i>Betty E. Geoghegan</i>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>metastatic cancer of the colon</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>11 P.M. 11 19</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11/18/84</i> , 19 <i>84</i> , to <i>11/24</i> , 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>11/24</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><i>Michael J. Fisher</i>   |  | DEGREE<br><i>MD</i>  |  |   |  | 22c. DATE SIGNED<br><i>11/24/84</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Michael J. Fisher</i>  |  | 22e. ADDRESS<br><i>Mercy Hospital Balto Md 21202</i>   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>Nov. 27, 1984</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Johns Leisters Cem.</i>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Westminster Carroll Md.</i>                    |  |
| 24. FUNERAL DIRECTOR<br><i>Edmund Owens</i>  |  | ADDRESS<br><i>2417</i>   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>NOV 27 1984</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>John Fisher</i>  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 8 3 5

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>MELVIN W. GERBEN   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 19 84                             |  | 2b. HOUR<br>11:40A M   |
| 3. SEX<br>Male   | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 2 41   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>43 YRS.                                  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Bon Secours Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Laborer | 12b. KIND OF BUSINESS OR INDUSTRY<br>A.A. Co.                                  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland  |   |   | 13b. COUNTY<br>---  | 13c. CITY OR TOWN<br>Baltimore   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Roland Gerben  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Blanche Hoffman            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |   | 16b. SOCIAL SECURITY NO.<br>217-40-2275   | 17. INFORMANT<br>ADDRESS<br>Egbert E. Gerben 1117 Longcross Rd. 21090       |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Septicemia as old myocardial infarction</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i></i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw this deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did not) view the body after death.   |   |   |   |  |  |
| 22b. SIGNATURE<br><i>J. Sapsiri, MD</i><br>DEGREE  |   |   |   | 22c. DATE SIGNED<br>11-20-84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Sapsiri   |   |   |   | 22e. ADDRESS<br>1614 Wilkens Avenue  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |   | 23b. DATE<br>11/23/84   | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cemetery                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hubbard Funeral Home, Inc. 4107 Wilkens Ave.   |   |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 23 1984                                | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson</i>                            |  |

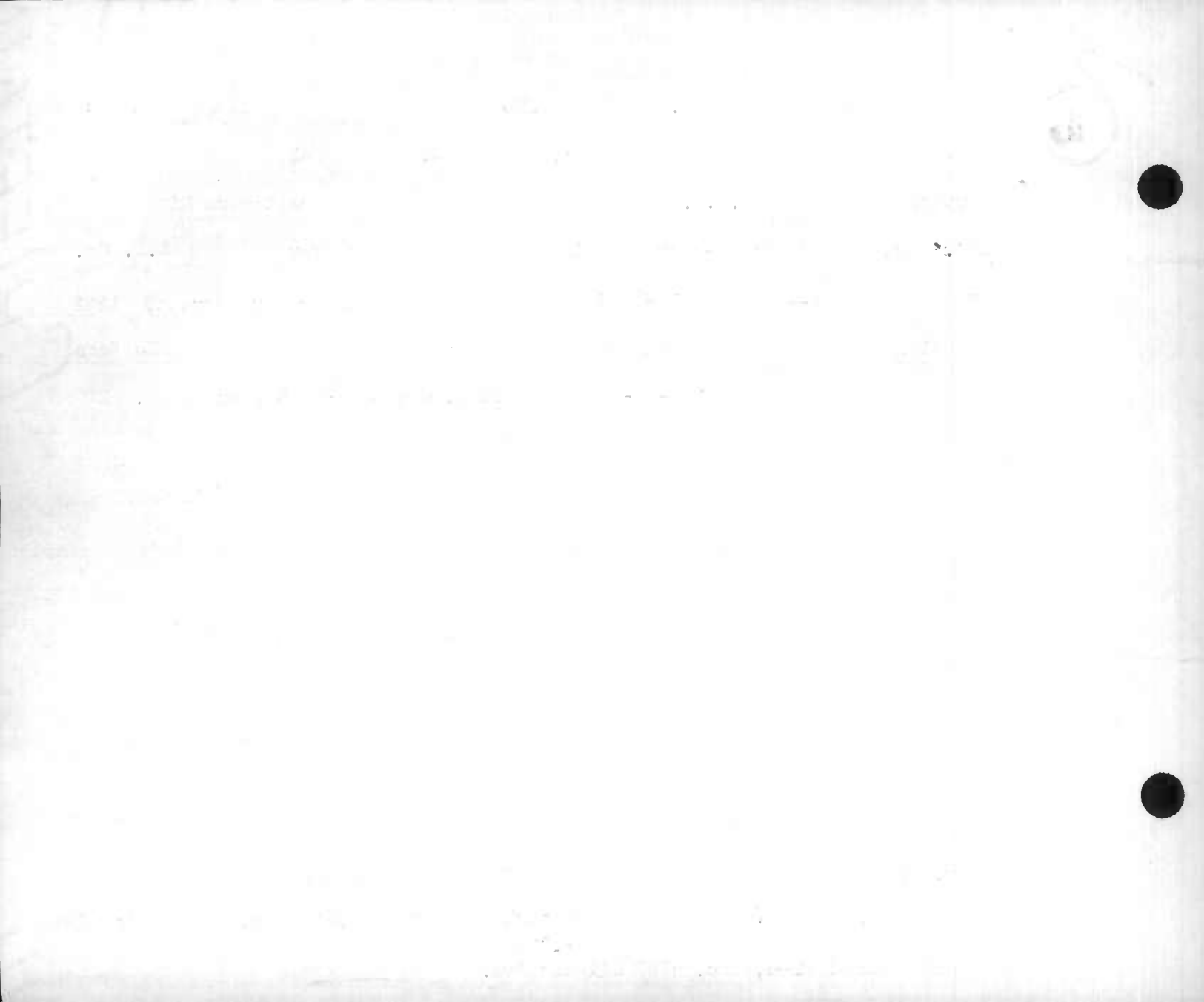
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 4 2 9 8 3 6   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME FIRST MIDDLE LAST<br>Eleanor May Gerhard  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>NOVEMBER 5, 1984  |  | 2b. HOUR<br>4:45 PM  |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>11/5/1932  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>52 YRS.   |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Ohio   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. AGNES HOSPITAL |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Clerk   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Mont. Ward  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.  |  | 13b. CITY OR TOWN<br>Balto  |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13d. STREET ADDRESS<br>2505 Poplar Drive 21207   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Claude Daiker   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Gladys Vandling   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>130-24-6141  |  | 17. INFORMANT ADDRESS<br>James Gerhard Same as # 13   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio-Respiratory Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Metastatic Carcinoma of stomach</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br>10/17/84   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Carcinoma of stomach<br>feeding jejunostomy                                 |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br>N.A.  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>N.A.   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/15/84, 1984, to 11/5/84, 1984, that (I) (we) last saw the deceased alive on 11/5/84, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Samir A. Dalal   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>11/5/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SAMIR A. DALAL  |  |   |  | 22e. ADDRESS<br>900 CATON AVE   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation   |  | 23b. DATE<br>11-6-84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Security Process  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Md.   |  |
| 24. FUNERAL DIRECTOR NAME<br>MacNabb Funeral Home  |  |   |  | ADDRESS<br>Catonsville Md   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 7 1984  |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY) |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
|---|--|--|--|---|--|--|--|---------------------------------|--|---|--|--------------------------------|--|--|--|--------------------------------------|--|---|--|-----------------------------------|--|
| LEONARD   |  | MALE   |  | NEGROID   |  | March 14, 1900   |  | 84 YRS.                         |  | VIRGINIA  |  | U.S.A.                         |  |  |  | Baltimore City, MD.                  |  | Retired   |  | Industry                          |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN               |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS / ZIP CODE |  |  |  |                                      |  |   |  |                                   |  |
| Baltimore   |  | MERCY Hospital   |  | Md.   |  |  |  | Balto.                          |  | YES   |  | 1512 E. Preston St.            |  | 21213  |  |                                      |  |   |  |                                   |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT                   |  | ADDRESS   |  |                                |  |  |  |                                      |  |   |  |                                   |  |
| DAVID   |  | CLARA  |  | NO  |  | 214-03-3150  |  | FCCA V. G. Holson               |  | 1512 E. Preston St.   |  |                                |  |  |  |                                      |  |   |  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |   |  |  |  |                                 |  |   |  |                                |  |  |  |                                      |  |   |  |                                   |  |
| PART 1. DEATH WAS CAUSED BY:  |  |  |  |   |  |  |  |                                 |  |   |  |                                |  |  |  |                                      |  |   |  |                                   |  |
| IMMEDIATE CAUSE (a) Myocardial Infarction.  |  |  |  |   |  |  |  |                                 |  |   |  |                                |  |  |  |                                      |  |   |  |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease.  |  |  |  |   |  |  |  |                                 |  |   |  |                                |  |  |  |                                      |  |   |  |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |   |  |  |  |                                 |  |   |  |                                |  |  |  |                                      |  |   |  |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |  |  |   |  |  |  |                                 |  |   |  |                                |  |  |  |                                      |  |   |  |                                   |  |
| S/P. Coronary Artery Disease with secondary seizure disorder.   |  |  |  |   |  |  |  |                                 |  |   |  |                                |  |  |  |                                      |  |   |  |                                   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |                                 |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                |  |  |  |                                      |  |   |  |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |                                 |  |   |  |                                |  |  |  |                                      |  |   |  |                                   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |                                 |  |   |  |                                |  |  |  |                                      |  |   |  |                                   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from May 1, 1983, to Nov. 4, 1984, that (I) (we) lost saw the deceased alive on Oct 27, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |                                 |  |   |  |                                |  |  |  |                                      |  |   |  |                                   |  |
| 22b. SIGNATURE  |  | DEGREE   |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |                                 |  | 22c. DATE SIGNED  |  |                                |  |  |  |                                      |  |   |  |                                   |  |
| George Taler, M.D.  |  |  |  |   |  |  |  |                                 |  | Nov 5, 1984   |  |                                |  |  |  |                                      |  |   |  |                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |   |  |  |  |                                 |  |   |  |                                |  |  |  |                                      |  |   |  |                                   |  |
| GEORGE TALER, M.D.  |  | 600 Light St. Balto. Md. 21230   |  |   |  |  |  |                                 |  |   |  |                                |  |  |  |                                      |  |   |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY                                |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |                                 |  |   |  |                                |  |  |  |                                      |  |   |  |                                   |  |
| Burial  |  | 11-8-84  |  | Balto. Cemetery   |  | Balto., Md.  |  |                                 |  |   |  |                                |  |  |  |                                      |  |   |  |                                   |  |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR  |  |   |  | 25b. REGISTRAR'S SIGNATURE   |  |                                 |  |   |  |                                |  |  |  |                                      |  |   |  |                                   |  |
| Calvin B. Scruggs   |  | NOV 5 1984   |  |   |  | John Davidson-Randall  |  |                                 |  |   |  |                                |  |  |  |                                      |  |   |  |                                   |  |

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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |   |   |   |                              |  |  |
|--|--|--|--|---|---|---|------------------------------|--|--|
| <div style="text-align: right;">8 4 2 9 8 3 8</div> <div style="text-align: center;"> <b>CERTIFICATE OF DEATH</b><br/>           REG. NO.         </div>   |  |  |  |   |   |   |                              |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JENNIE P. Gibbons</b>   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>14</b> YEAR <b>84</b> |   | 2b. HOUR<br><b>1:33 P.M.</b> |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>1</b> DAY <b>5</b> YEAR <b>04</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.   |                              | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |                              |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto. City</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Mercy Hospital</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |                              | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Homemaking</b>   |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                              | 13e. STREET ADDRESS<br><b>429 52nd. St. Balto., Md. 21224</b>  |  |
| 14. FATHER'S NAME<br>FIRST <b>Thomas</b> MIDDLE <b></b> LAST <b>Peden</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Harriett</b> MIDDLE <b></b> LAST <b>Hand</b>   |   |   |                              |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.<br><b>174-16-3913</b>   |  | 17. INFORMANT ADDRESS<br><b>Lawrence Gibbons 509 Fuselage Ave. 21221</b>  |   |   |                              |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>HYPOTENSION</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>SEPSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>BOWEL OBSTRUCTION</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |   |   |                              |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>MYOTHYROIDISM</b>  |  |  |  |   |   |   |                              |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |                              |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |                              |  |  |
| 22a. I certify that (this hospital) attended the deceased from <b>1982</b> , 19____, to <b>11/14/84</b> , 19____, that (we) lost saw the deceased alive on <b>11/14/84</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If wet aid) did not view the body after death.                                |  |  |  |   |   |   |                              |  |  |
| 22b. SIGNATURE<br><b>E. J. Miller MD</b>   |  |  |  | DEGREE<br><b>MD</b>   |   |   |                              | 22c. DATE SIGNED<br><b>11/14/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Folkner</b>  |  |  |  | 22e. ADDRESS<br><b>MERCY Hospital</b>   |   |   |                              |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11-17-84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>South Fork Cemetery</b>  |   | 23d. LOCATION<br>CITY OR TOWN <b>South Fork, Pennsylvania</b> COUNTY <b></b> STATE <b>MD</b>    |                              |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Lasspho Funeral Home</b><br>ADDRESS <b>1401 BELAIR RD. BALTO. MD 21236</b>   |  |  |  | 25. DATE REC'D. BY REGISTRAR <b>NOV 20 1984</b><br>REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>  |   |   |                              |  |  |

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140241-70974

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1 - STATE REGISTRAR   |   | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  | 8 4 2 9 8 3 9<br>REG. NO.   |                                   |
|---|---|---|--|---|-----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>CURTIS GIBSON   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 29 84                  |   | 2b. HOUR<br>2 <sup>a</sup> M      |
| 3 SEX<br>Male   | 4 RACE<br>Black   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 3 25  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>59 YRS.<br>IF UNDER 1 YEAR: MONTHS DAYS<br>IF UNDER 24 HRS: HOURS MIN. |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N.C.   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |                                   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE CITY   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST AGNES |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MD 13b. COUNTY 13c. CITY OR TOWN Baltimore 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |   | 13e. STREET ADDRESS / ZIP CODE<br>110 N. Denison St. 21229       |   |                                   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Will Gibson   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Craner Quick   |  |   |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>Yes   |   | 16b. SOCIAL SECURITY NO.<br>245-28-0860   |  | 17. INFORMANT<br>ADDRESS<br>Millie A. Mills 110 N. Denison St.  |                                   |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>(IMMEDIATE CAUSE (a)) <u>Septic shock</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <u>Renal failure</u><br>(c) <u>Hypertensive hyperglycemic coma</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>Short bowel syndrome</u> |   |   |  |   |                                   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                      |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                            |                                   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11-23</u> , 19 <u>84</u> , to <u>11-29</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>11-29</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |   |  |   |                                   |
| 22b. SIGNATURE<br><u>Qui Dien Huynh</u>   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><u>11-29-84</u>   |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>QUI DIEN HUYNH   |   | 22e. ADDRESS<br>ST AGNES HOSP. 900 EATON, BALTIMORE, MD 21229   |  |   |                                   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  | 23b. DATE<br>12/4/84  | 23c. NAME OF CEMETERY OR CREMATORY<br>Wayman's Chapel Cem.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Hamlet N.C.   |                                   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H 1101 E. North Ave.   |   | 25a. DATE REC'D. BY REGISTRAR<br>DEC 4 1984   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Jeha Davidson-Randall</u>  |                                   |

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11-2



TO HOSPITAL OR ATTENDING PHYSICIAN: The Registrar requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be retained for use on the burial transit permit. Then please remove carbon papers, sign 1 and 2 and return them to the Registrar. Page 3 should be retained by the funeral director.

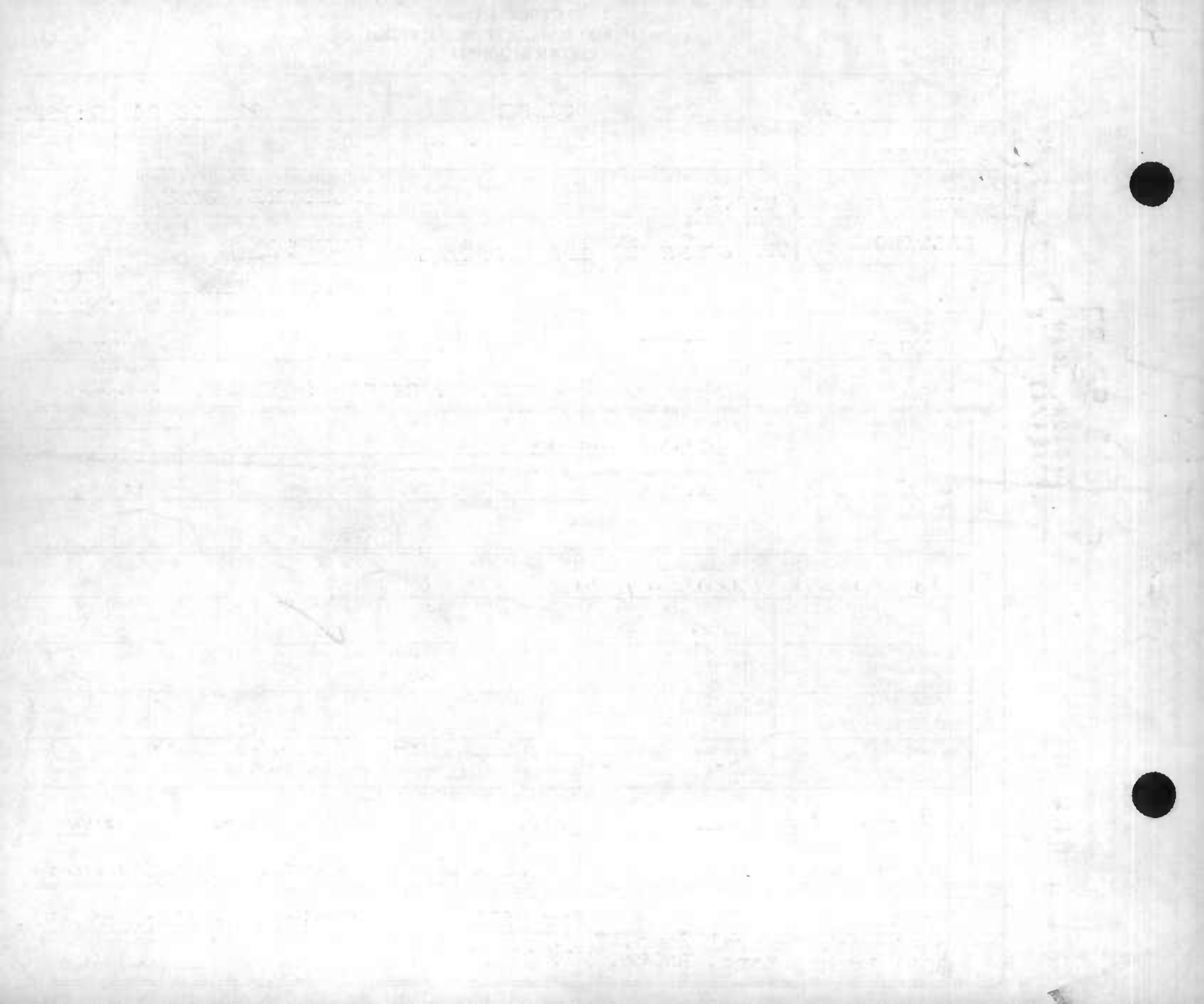
IMPORTANT: If item 21 is marked or item 18 shows any injury or other trauma, the attending physician should complete the report on the back of this certificate.

DHMH - 16 60M 7/84  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 4 2 9 8 4 0  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JOAN I GIBSON</b>  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 28 84</b>   |  |  |  |
| 3. SEX<br><b>FEMALE</b>   |  |  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MARCH 24 1947</b>   |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>37</b>  |  |  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS</b>  |  | 8. IF UNDER 24 HRS<br>HOURS MIN.<br><b>7:10PM</b>  |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>   |  | 10. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 12. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |  |
| 13. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  | 15. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOMEMAKER</b>  |  | 16. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>   |  |
| 17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>17a. STATE<br><b>MD.</b>   |  | 17b. COUNTY<br><b>HOWARD</b>   |  | 17c. CITY OR TOWN<br><b>SAVAGE</b>   |  | 17d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 18. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>SAMUEL T. GIVENS</b>   |  |  |  | 19. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>BIRDIE CLINE</b>   |  |  |  |
| 20. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 21. SOCIAL SECURITY NO.<br><b>230-64-7675</b>  |  | 22. INFORMANT<br><b>EDW. W. GIBSON (HUSBAND)</b>   |  | 23. ADDRESS<br><b>SAME ADDRESS</b>   |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost:<br>(b) <b>SEPSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>48 HRS</b> |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>IDIOPATHIC CARDIOMYOPATHY</b>  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/27</u> 19 <u>84</u> to <u>11/28</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>11/28</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.         |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>KATH KAUFMAN</b>   |  |  |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>11/28/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KATH KAUFMAN</b>  |  |  |  | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL BALT. MD 21205</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Removal</b>   |  | 23b. DATE<br><b>11-30-84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Covington-Allegheny, VA.</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>Schimunek Fuenral Home, Inc.<br/>3331 Brehms Lane, Balto. Md. 21213</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 4 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Davidson-Randall</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

|  |  |   |  |
|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.  |  |
| I. DECEASED NAME<br>(TYPE OR PRINT)  |  | 2a. DATE OF DEATH   |  |
| FIRST MIDDLE LAST<br><i>Louise C. GIBSON</i>   |  | MONTH DAY YEAR<br><i>November 21, 1984</i>  |  |
| 3. SEX<br><i>female</i>  |  | 2b. HOUR<br><i>12:20<sup>P</sup></i>  |  |
| 4. RACE<br><i>black</i>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>12 10 27</i>   |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>56</i> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Bradshaw, Md.</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Maryland General Hospital</i> |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 13a. STATE<br><i>Md.</i>   |  | 13b. COUNTY<br><i>BALTO.</i>  |  |
| 13c. CITY OR TOWN<br><i>BALTO.</i>   |  | 13e. STREET ADDRESS / ZIP CODE<br><i>3025 E. Federal St. 21213</i>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES<br><i>no</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>220-20-7245</i>  |  |
| 17. INFORMANT<br>ADDRESS<br><i>Denise Turner 4503 Penhurst Ave.</i>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Metastatic Oat cell carcinoma from the left LUNG to</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br><i>the liver, pericardium, lymph nodes, right kidney,</i><br><i>with, almost complete replacement of the left lung.</i>   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>LUNG to</i>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>19</i>  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                     |  |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>November 7</i> , 19 <i>84</i> , to <i>November 21</i> , 19 <i>84</i> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <i>November 21</i> , 19 <i>84</i> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |   |  |
| 22b. SIGNATURE<br><i>S. Ramesh</i>   |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Ramesh Sabapathi, M.D.</i>   |  | 22e. ADDRESS<br><i>c/o Maryland General Hospital</i>  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>11/27/84 burial</i>   |  | 23b. DATE<br><i>11/27/84</i>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><i>Mt. Auburn Cem.</i>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore Md.</i>  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Leroy O. Dyett 4600 Liberty Hgts. Ave.</i>  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>NOV 28 1984</i>   |  |
|  |  | REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: A low rate for the death certificate may be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been completed, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. It should be returned to the State Dept. of Health and Mental Hygiene prior to the removal of the body. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

84 / 29842

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |  |   |  |  |   |   |  |
|---|--|---|--|---|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>John M Gibula  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11/03/84                        |   |  | 2b. HOUR<br>12:12 PM   |   |   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct. 27, 1928 <sup>AR</sup>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>56 YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>The Johns Hopkins Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Machinist  |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>Md.   |  |   | 13b. COUNTY  |   | 13c. CITY OR TOWN<br>Baltimore                         |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Gibula   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Genevieve Glembecki   |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |   |   |  |
| 16b. SOCIAL SECURITY NO.<br>218-22-2391   |  |   | 17. INFORMANT ADDRESS<br>Dorothy Gibula 815 S. Milton Ave.             |   |  |  |   |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST<br>DUE TO, OR AS A CONSEQUENCE OF (b) PROBABLE VENTRICULAR ARRHYTHMIA<br>DUE TO, OR AS A CONSEQUENCE OF (c) SEVERE ASCVD<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>MINUTES 30 minutes<br>YEARS years |  |   |  |   |  |  |   | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a<br>ADENOCARCINOMA OF THE LUNG |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |
| 22a. I certify that (this hospital) attended the deceased from 10/12, 19 84, to 11/3, 19 84, that (I) (we) lost saw the deceased alive on 11/3, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |   |   |  |
| 22b. SIGNATURE<br>Hiram I Levitsky MD   |  |   | DEGREE   |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br>11/3/83   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Hiram I Levitsky MD  |  |   | 22e. ADDRESS<br>C/O J.N.H.   |   |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |   | 23b. DATE<br>11-7-84   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens of Faith |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Md.  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>John M. Weber & Sons Inc.   |  |   | ADDRESS<br>401 S. Chester St.  |   |  | 25. DATE REC'D. BY REGISTRAR<br>NOV 8 1984   |   | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randall   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in person.

DHMH-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

|  |  |   |  |   |   |  |                                |   |  |  |
|--|--|---|--|---|---|--|--------------------------------|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>EDWARD GLENN GILBERT  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 5 1984                 |   |   | 2b. HOUR<br>4:30AM   |                                |   |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Feb. 6, 1923  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>61 YRS.   |                                | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Kentucky  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |                                |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South Baltimore Gen. Hosp. |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Teacher (ret)  |                                | 12b. KIND OF BUSINESS OR INDUSTRY<br>Public sch.  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.  |  |   |  |   | 13b. COUNTY<br>Anne Arundel   |  | 13c. CITY OR TOWN<br>Baltimore |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Edward Gilbert   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Leona Byrley                     |  |                                |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WWII   |  | 17. INFORMANT<br>235-28-5625  |   | 17. ADDRESS<br>Mrs. Blanche Gilbert (wife) Same # as 13  |                                |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Coronary artery disease and</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Hypertension</u>  |  |   |  |   |   |  |                                |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Diabetes mellitus</u>  |  |   |  |   |   |  |                                |   |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                                |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                                |   |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>10-17</u> , 19 <u>88</u> , to <u>11-5</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>6-19</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |   |  |                                |   |  |  |
| 22b. SIGNATURE<br><u>Morton Krieger</u>  |  |   | DEGREE<br><u>MD</u>  |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                |   | 22c. DATE SIGNED<br><u>Nov 5, 1984</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Morton Krieger M.D.   |  |   | 22e. ADDRESS<br>606 Hammonds Lane Brooklyn Park, Md.                   |   |   |  |                                |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |   | 23b. DATE<br>11/8/84   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Sunset Mem. Gardens Cleveland Bradley Tenn. |  |                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>E. Barnes  |  |   | ADDRESS<br>Fleming Funeral Service - Benson, Md.                       |   |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 9 1984  |                                |   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |   |  |   |  |  |
|--|--|--|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Evelyn</i> <i>Gilbert</i>   |  |  | 2a. DATE OF DEATH<br>MONTH <i>11</i> DAY <i>22</i> YEAR <i>89</i> |   |  | 2b. HOUR<br><i>1:15 AM</i>  |  |  |
| 3. SEX<br><i>F</i>   |  | 4. RACE<br><i>NEGRO</i>  |   | 5. DATE OF BIRTH<br>MONTH <i>9</i> DAY <i>9</i> YEAR <i>02</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>82</i>  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>USA N.Y.</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Balto.</i> MD.                                       |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Balto.</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Mercy Hospital</i> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OR WORK FOR MOST OF WORKING LIFE)<br><i>Doctorian</i> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>J. H. Hosp</i>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <i>md</i>   |  | 13b. COUNTY<br><i>Balto</i>  |   | 13c. CITY OR TOWN<br><i>Balto</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST <i>Charles</i> MIDDLE <i>Spencer</i> LAST <i>Spencer</i>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <i>Olivia</i> MIDDLE <i>Spencer</i> LAST <i>Spencer</i>  |   |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <i>No</i>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES) <i>063-14-9880</i>   |   | 17. INFORMANT<br>ADDRESS <i>John Spencer 1733 N. Patterson St. B.</i>   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>ventricular arrhythmia</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>cardiac arrest</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)   |  |  |   |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |  |   |  |  |
| 22b. SIGNATURE<br><i>Marie Amos Dobyns</i>   |  | DEGREE   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br><i>11/22/89</i>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>MARIE AMOS DOBYNS</i>  |  | 22e. ADDRESS<br><i>301 St. Paul Place Balto, Md</i>  |   |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>11/28/89</i>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>New Cathedral</i>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Balto. Md</i>                                  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <i>Lois J. Jones</i> ADDRESS <i>Home 1304 N. Central Ave</i>  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><i>NOV 26 1989</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>John Davidson Anderson</i>                                     |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is marked, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |   |   |   | REG. NO. 84 29845   |  |
|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Helen Louise Gilbert<br>HELEN LOUISE GILBERT   |   |   | 2a. DATE OF DEATH<br>Nov. 11 84<br>11 11 84                                   |   | 2b. HOUR<br>4:44 PM                          |
| 3. SEX<br>FEMALE  | 4. RACE<br>white  | 5. DATE OF BIRTH<br>MONTH YEAR<br>Oct. 21 99  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS.                                    |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.    |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>Massachusetts  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                    |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South Baltimore General Hos. |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>N/A     |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. CITY 13c. STREET ADDRESS / ZIP CODE<br>Md. Baltimore Baltimore 1816 Wenderover Rd. 21234  |   |   | 13d. INSIDE CITY LIMITS?<br>YES NO <input checked="" type="checkbox"/>        |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles nmh White   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Louise nmh unknown   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No N/A  |   | 16b. SOCIAL SECURITY NO.<br>217070809   |   | 17. INFORMANT (granddaughter) 7810 Cypress<br>Carol Robertson Landing Rd.<br>Severn, MD. 21144  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIAC ARREST<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) ACUTE MYOCARDIAL INFARCTION.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) A.S.C.V.D.<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>Right hip Fracture.   |   |   |   |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |   |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>noon P.M. 10-29- 84  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br>Subject fell. |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK<br>AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21e. PLACE OF INJURY<br>Meridian Nursing Home   |   | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Hammonds Lane & Robinwood Rd. Md.                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/27/84, 1984, to 11/11/84, 1984, that (I) (we) last saw the deceased alive on 11/11/84, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |   |   |   |   |  |
| 22b. SIGNATURE<br>K. Williams M.D.  |   | DEGREE<br>M.D.  |   | 22c. DATE SIGNED<br>11/11/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |   | 22e. ADDRESS  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation   |   | 23b. DATE<br>Nov. 15/84   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Security Pro. Inc.  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Catonsville B.C. MD.  |   |   |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Singleton Funeral Home  |   | ADDRESS<br>Glen Burnie  |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 13 1984  |  |
| 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Rendell   |   |   |   |   |  |

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 3 4 6

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |  |  |   |  |   |  |
|--|--|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Clarence Gittings</i> |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>11/14/84</i> |  |  | 2b. HOUR<br><i>7:50 am</i>  |  |   |  |
| 3. SEX<br><i>M</i>   |  | 4. RACE<br><i>B</i>  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>11 20</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>94</i> YRS.                 |  | 7. UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>MARYLAND</i> |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD. |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Provident Hospital</i> |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY         |  |

|  |  |  |                          |  |  |  |   |  |   |  |
|--|--|--|--------------------------|--|--|--|---|--|---|--|
| 13a. STATE<br><i>Maryland</i>  |  |  | 13b. COUNTY              |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><i>2503 Violet Ave. 21215</i> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>William Gittings</i>       |  |  |                          |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Margret Smith</i>                                   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) |  |  | 16b. SOCIAL SECURITY NO. |  | 17. INFORMANT ADDRESS<br><i>Georgia 30314</i><br><i>Bernard Miller 645 Beckwith St. S.W. Atlanta</i> |  |   |  |   |  |

|   |  |   |  |
|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardio-Pulmonary Arrest</i> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>30 min</i> |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <i>Renal Failure</i>    |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |  |

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11/13</i> 19 <i>84</i> to <i>11/14</i> 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>11/14</i> 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (she) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><i>Clarence Smith</i>   |  | DEGREE   |  | 22c. DATE SIGNED<br><i>11/14/84</i>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Clarence Smith</i>  |  | 22e. ADDRESS   |  |  |  |  |  |

|   |  |                              |  |  |  |   |  |
|---|--|------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>                                |  | 23b. DATE<br><i>11-17-84</i> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Mount Calvary Cemetery Baltimore</i>                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore Maryland</i> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Vernon R. Bailey 1348 North Calhoun Street</i> |  |                              |  | 25a. DATE REC'D. BY REGISTRAR <i>NOV 20 1984</i> REGISTRAR'S SIGNATURE<br><i>John Davidson</i> |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, slavery injury, or other traumatic event, the medical examiner must be notified.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |   |   |  |   |  |  |  |
|--|--|--|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Donald M Gittings</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-1-84</b>                       |   |   | 2b. HOUR<br><b>8:16p.m.</b>  |   |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 13 28</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>56</b> YRS.                                      |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Michigan</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>                     |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>F.S.K.M.C.</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Accounting-</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Beth. Steel</b>  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  |  |   |   | 13b. CITY OR TOWN<br><b>Baltimore</b>                                   |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13d. STREET ADDRESS / ZIP CODE<br><b>452 Mirabile Lane 21224</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Clifford A. Gittings</b>  |  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Georgia E. Maze</b> |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>1945-1961</b> |   | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Inez D. Gittings Same as # 13e</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>anoxic brain damage.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |   |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |   |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                            |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>              |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>           |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)         |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)      |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                      |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 1, 19 84</b> to <b>Nov 1, 19 84</b> that (I) (we) last saw the deceased alive on <b>Nov 1, 19 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.    |  |  |   |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Edith Lepgold</b>   |  |  |   |   |   | DEGREE<br><b>MD</b>  |   | 22c. DATE SIGNED<br><b>11/1/84</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Edith Lepgold</b>  |  |  |   |   |   | 22e. ADDRESS   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |  |  | 23b. DATE<br><b>11-2-84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview</b>                   |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Duda-Ruck, Inc./</b>  |  |  |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 5 1984</b>                                     |   | 25b. REGISTRAR'S SIGNATURE<br><b>Jake Davidson-Randall</b>   |  |  |
| 7922 Wise Avenue Dundalk, MD. 21222  |  |  |   |   |   |  |   |  |  |  |



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**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

1- FOR  
 STATE  
 REGISTRAR

|  |                         |   |  |   |   |  |  |   |
|--|-------------------------|---|--|---|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Lucille Golden</b>   |                         |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>MONTH DAY YEAR<br><b>11 17 19 84</b> |   |   | 2b. HOUR<br>M<br><b>9:30A</b>  |  |   |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>Black</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 10 35 49 YRS.</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>49</b>                                 | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS.<br>HOURS MIN.  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>11 17 19 84</b>                         |  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                        |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1117 E. Belvedere Ave Apt #3</b> |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                            |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br><b>MD</b>  |                         |   | 13b. COUNTY  | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>1127 E. Belvedere Ave.</b>                                     |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Toomer</b>   |                         |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lucy Jones</b>           |   |   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |                         |   | 16b. SOCIAL SECURITY NO.<br><b>216-34-6139</b>                               |   | 17. INFORMANT ADDRESS<br><b>Joann Harris New Shiloh Bapt. Church</b>                            |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic renal failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |                         |   |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |                         |   |  |   |   |  |  |   |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |   | 20. AUTOPSY?<br>(HO) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |   |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |   |  |   |   |  |  |   |
| ACTUAL SIGNATURE<br>  |                         | TITLE (SPECIFY)<br>M.D. <b>Assistant</b> MEDICAL EXAMINER   |  |   |   | DATE SIGNED <b>11/22/84</b>  |  |   |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Gregory R. Kauffman, MD.</b>  |                         | ADDRESS <b>111 Penn Street, Baltimore, MD 21201</b>   |  |   |   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |                         | 23b. DATE<br><b>11/23/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Zion Cem.</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD</b>                        |  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>  |                         |   |  | ADDRESS<br><b>1101 E. North Ave,</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 23 1984</b>                                      |  | 25b. REGISTRAR'S SIGNATURE<br> |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. IF YOU HAVE FILES TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



100% COTTON FIBER

DOWN

WINTER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

84 29849  
REG. NO.

|   |  |   |  |   |  |   |  |  |  |                 |               |   |                            |  |  |   |  |
|---|--|---|--|---|--|---|--|--|--|-----------------|---------------|---|----------------------------|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>BESSIE</b>   |  | FIRST <b>Goldsbrough</b>  |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH  |  | MONTH <b>11</b> | DAY <b>22</b> | YEAR <b>84</b>                                    | 2b. HOUR<br><b>3:50 AM</b> |  |  |   |  |
| 3 SEX<br><b>FEMALE</b>  |  | 4 RACE<br><b>BLACK</b>  |  | 5. DATE OF BIRTH  |  | MONTH <b>12</b>   |  | DAY <b>24</b>  |  | YEAR <b>98</b>  |               | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b> YRS. |                            | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b> |  | IF UNDER 24 HRS<br>HOURS <b></b> MIN. <b></b> |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>USA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. MD.</b>                                       |  |  |  |                 |               |   |                            |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GPA 607 Penna Ave</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>N/a</b>   |  |  |  |                 |               |   |                            |  |  |   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>USA</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>607 Penna. Ave.</b>  |  | 21201           |               |   |                            |  |  |   |  |
| 14. FATHER'S NAME<br>FIRST <b>Thomas</b> MIDDLE <b></b> LAST <b>Mills</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Molly</b> MIDDLE <b></b> LAST <b>Gumby</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |  |   |  |  |  |                 |               |   |                            |  |  |   |  |
| 16b. SOCIAL SECURITY NO.<br><b>218-09-7871</b>  |  | 17. INFORMANT<br>ADDRESS <b>Evetta Henry 622 Franklin Dr. Perth Amboy, NJ.</b>  |  |   |  |   |  |  |  |                 |               |   |                            |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchogenic Carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>            |  |   |  |   |  |   |  |  |  |                 |               |   |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>H/c Carbon Monoxide Accident</b>   |  |   |  |   |  |   |  |  |  |                 |               |   |                            |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                 |               |   |                            |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |                 |               |   |                            |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET <b></b> CITY OR TOWN <b></b> COUNTY <b></b> STATE <b></b>   |  |   |  |  |  |                 |               |   |                            |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-16</b> , 19 <b>84</b> , to <b>11-22</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>11-17</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |  |  |                 |               |   |                            |  |  |   |  |
| 22b. SIGNATURE<br><b>[Signature]</b>  |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  |   |  |  |  |                 |               | 22c. DATE SIGNED<br><b>11-22-84</b>               |                            |  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>[Signature]</b>   |  | 22e. ADDRESS<br><b>1600 M7 Royal Ave, Baltimore MD 21217</b>  |  |   |  |   |  |  |  |                 |               |   |                            |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |  | 23b. DATE<br><b>11-24-84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore, MD.</b> COUNTY <b></b> STATE <b></b>                |  |  |  |                 |               |   |                            |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>William C. Brown</b> ADDRESS <b>1206-08 W. North Ave.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 5 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |   |  |  |  |                 |               |   |                            |  |  |   |  |

BP \_\_\_\_\_

A

REBUT NOTION NO. 2

WILLIAM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 4 2 9 8 5 0  
REG. NO.

|  |  |  |   |   |  |  |  |
|--|--|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LIZA</b>  |  |  | 2a. DATE OF DEATH<br>MONTH <b>NOVEMBER</b> DAY <b>22</b> YEAR <b>1984</b> |   |  | 2b. HOUR<br><b>11:55 P.M.</b>  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>Caucasian</b>  |   | 5. DATE OF BIRTH<br>MONTH <b>MAY</b> DAY <b>5</b> YEAR <b>1905</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Russia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>AMERICAN</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>LEVINDAVE HEBREW GERIATRIC CENTER - HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>NONE</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>NONE</b>   |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>  |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST <b>VOLKIE</b> MIDDLE <b>KRAMERMAN</b> LAST <b>UNKNOWN</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>HANNA</b> MIDDLE <b>UNKNOWN</b> LAST <b>UNKNOWN</b>   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |  |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>212-92-7254</b>   |  | 17. INFORMANT <b>MRS. ANNA TEPLITSKY</b> APT. <b>B</b><br><b>8008 WOODGATE CT. BALTO., MD 21207</b>  |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR <b>A.M.</b> MONTH <b>10</b> DAY <b>26</b> YEAR <b>1984</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____   |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from <b>10/26</b> , 19 <b>84</b> , to <b>11/22</b> , 19 <b>84</b> , that (we) last saw the deceased alive on <b>11/22</b> , 19 <b>84</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) view the body after death.                   |  |  |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Estrelita O. Kn.</b>  |  | DEGREE <b>MD</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |   | 22c. DATE SIGNED<br><b>11/23/84</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ESTRELITA O. KN.</b>   |  | 22e. ADDRESS<br><b>LEVINDAVE HEBREW GERIATRIC CENTER - HOSPITAL</b>  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |  | 23b. DATE<br><b>NOV. 23, 1984</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SHAAREI TFILOH</b>   |  | 23d. LOCATION<br><b>BALTIMORE</b> COUNTY <b>MARYLAND</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 28 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Davidson-Randall</b>  |  |

MEDICAL CERTIFICATION

1

RECEIVED

10/10/11



10/10/11



STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

8 4 2 9 8 5 1

REG. NO.

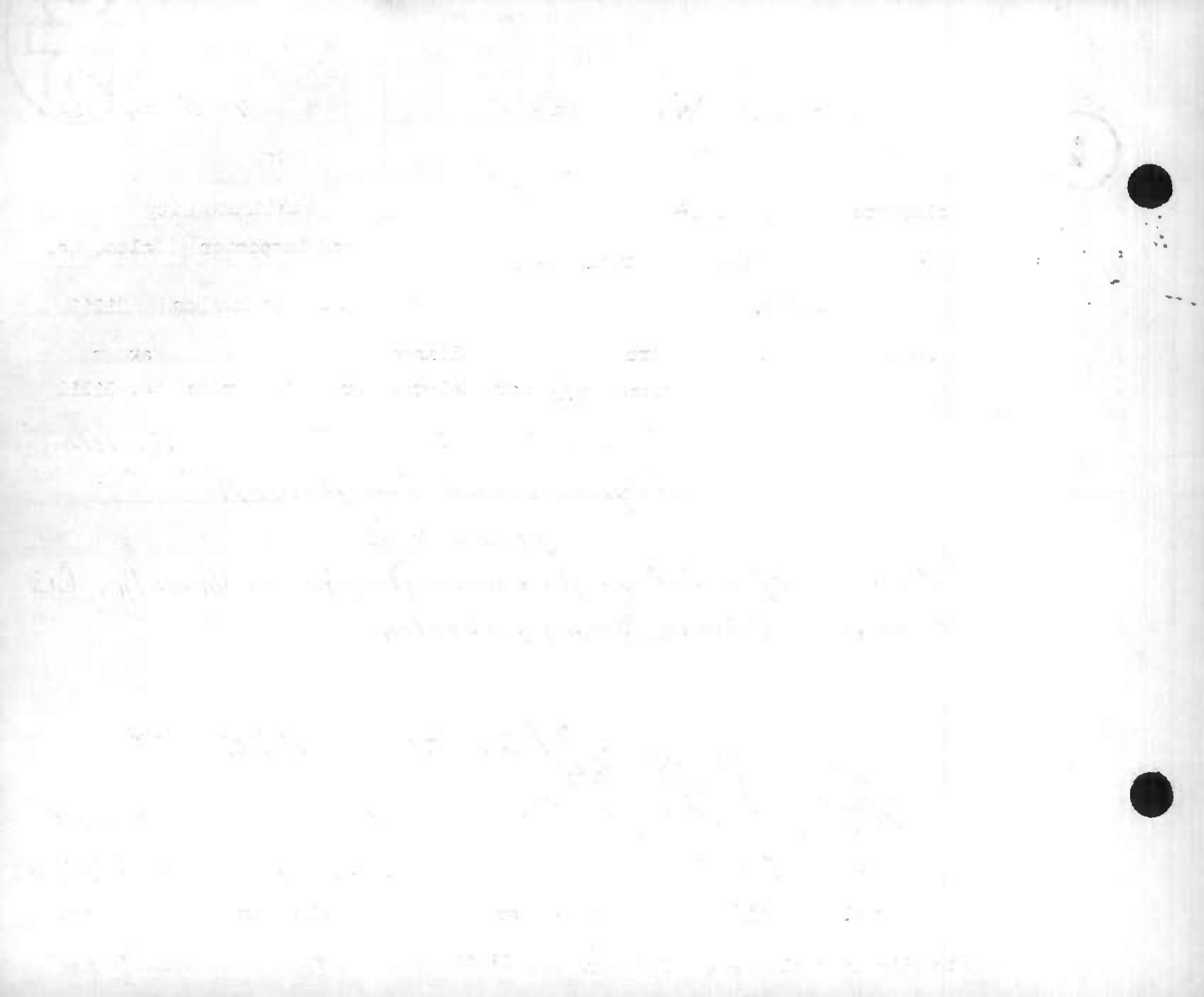
|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>WESLEY W. GORE</b>   |  | 2b. DATE OF DEATH MONTH DAY YEAR<br><b>11-5-84</b>   |  | 2c. HOUR<br><b>8:30 AM</b>  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>9-26-05</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS.<br><b>79 YRS.</b>                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Edgewood Nursing Home</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Road Inspector</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Balto. Co.</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. CITY OR TOWN<br><b>MD Balto.</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>715 Murdock Road 21212</b>  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>John W. Gore</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Elizabeth Warner</b>  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  |   |  |
| 16a. SOCIAL SECURITY NO.<br><b>213-01-2975</b>   |  | 17. INFORMANT ADDRESS<br><b>Mary Dolores Gore 715 Murdock Rd. 21212</b>  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>myocardial Ischemia</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCVD</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>CANCER of the Colon - Anemia. Peripheral Vascular Dis</b>   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION<br><b>5-29-81</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>CANCER - Resection of Colon</b>   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/21/81</b> to <b>11/5/84</b> , that (I) (we) last saw the deceased alive on <b>11-3-84</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (us) (us) signed this death certificate.                 |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Anthony F. Carozzi</b>  |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED<br><b>11-5-84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Anthony F. Carozzi</b>   |  | 22e. ADDRESS<br><b>6000 Bellme Ave BALTO MD 21212</b>  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11/8/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Mitchell-Wiedefeld Home</b>  |  | ADDRESS<br><b>6500 York Rd. 21212</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 7 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72-hour death report with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

DHMH - 16 50M 4/83  
(VRS 15, 4)1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 8 5 2

REG. NO.

|   |  |   |   |  |   |
|---|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>VERA M. GOSNELL   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 11 84   |  | 2b. HOUR<br>8:15 PM   |
| 3. SEX<br>Female  | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>March 13 1921   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>63  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                     |   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Clerk                       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Drug Store   |
| 13a. STATE<br>Maryland  | 13b. COUNTY<br>-   | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Andrew Maximuck   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Helen ?/   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215 01 1855   | 17. INFORMANT<br>Alexander C. Gosnell, husband  |   | ADDRESS<br>Same  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>INTRACRANIAL bleed</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |   |   |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 2b. PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (if <u>this hospital</u> ) attended the deceased from <u>11 9</u> , 19 <u>84</u> , to <u>11/11</u> , 19 <u>84</u> , that (if <u>he</u> ) lost<br>saw the deceased alive on <u>11/11</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (if <u>we</u> ) (did not) view the body after death. |  |   |   |  |   |
| 22b. SIGNATURE<br><u>David S. Dunn</u>  |  | DEGREE<br><u>MD</u>   |   | 22c. DATE SIGNED<br><u>11/11/84</u>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>DAVID S. DUNN</u>   |  | 22e. ADDRESS<br><u>201 UNIVERSITY PKWY</u>  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Burial</u>   |  | 23b. DATE<br><u>11/13/84</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Moreland Memorial Park</u>                             |  | 23d. LOCATION<br><u>Baltimore, Maryland</u>   |
| 24. FUNERAL DIRECTOR<br><u>Prudzinski Funeral Home</u>  |  | 25a. DATE RECEIVED<br><u>NOV 13 1984</u>  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Richard R. Rindell</u>                        |   |

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |                              |  |  |  |  |  |  |  |  |  |
|--|--|------------------------------|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 8 4 2 9 8 5 3<br>REG. NO.    |  |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | Catherine R. Greff           |  | 2a. DATE OF DEATH  |  | 4/27/84  |  | 2b. HOUR   |  | 5:55 AM  |  |
| 3. SEX   |  | female                       |  | 4. RACE  |  | white  |  | 5. DATE OF BIRTH   |  | 9 11 00  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | Italy                        |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | U.S.A.   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 84 YRS.  |  |
| 10. CITY OR TOWN OR DEATH  |  | Baltimore                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | France Scott Key   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  | Baltimore City MD.   |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | Seamstress                   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  | Oak Crest Mtg  |  |  |  |  |  |
| 13a. STATE   |  | Md.                          |  | 13b. COUNTY  |  | Balt.  |  | 13c. CITY OR TOWN  |  |  |  |
| 14. FATHER'S NAME  |  | Antonio                      |  | 15. MOTHER'S MAIDEN NAME   |  | Caroline   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | no                           |  | 16b. SOCIAL SECURITY NO.   |  | 216-09-2863  |  | 17. INFORMANT  |  | Ray Greff - 1211 Dundalk Ave                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  | PART I. DEATH WAS CAUSED BY: |  | IMMEDIATE CAUSE (a)  |  | candid pulmonary arrest  |  | DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |
|  |  |                              |  | (b)  |  | sepsis   |  | DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |
|  |  |                              |  | (c)  |  | urinary tract infection  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                 |  | seizure activity             |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |                              |  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  |                              |  | 21b. TIME OF INJURY  |  | HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) |  |  |  |
|  |  |                              |  |  |  | P.M. 19  |  |  |  |  |  |
| 21d. INJURY OCCURRED   |  |                              |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |  |  | 21f. LOCATION  |  |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                              |  |  |  |  |  | CITY OR TOWN   |  | COUNTY STATE   |  |
|  |  |                              |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from   |  | 4/26/84                      |  | 19 84  |  | to   |  | 4/27   |  | 19 84  |  |
| saw the deceased alive on  |  | 4/27/84                      |  | 19 84  |  | and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE   |  | Joseph A. Carrese MD         |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                          |  | 22c. DATE SIGNED   |  | 4/27/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | Joseph A. Carrese            |  | 22e. ADDRESS   |  | FSKMC, Balt MD.  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | Burial                       |  | 23b. DATE  |  | 11/30/84   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | Oak Lawn   |  |
|  |  |                              |  |  |  |  |  | 23d. LOCATION  |  | CITY OR TOWN COUNTY STATE                                      |  |
|  |  |                              |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR   |  | Walter Dalnowski             |  | 25a. DATE REC'D. BY REGISTRAR  |  | NOV 29 1984  |  | 25b. REGISTRAR'S SIGNATURE   |  | John E. ...  |  |
| NAME   |  | Walter Dalnowski             |  | ADDRESS  |  | 1005 Dundalk Ave   |  |  |  |  |  |

NO 200

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 8 5 4

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |  |   |
|--|--|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>THERESA M GRAHAM</b>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>NOVEMBER 23, 1984</b>                                     |  | 2b. HOUR<br><b>4:05</b> M   |
| 3. SEX<br><b>Fem.</b>  | 4. RACE<br><b>Cau.</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 22 23</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>61</b> YRS.                                    |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Key Punch - Md. State</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br><b>Md.</b>   | 13b. COUNTY<br><b>-</b>  | 13c. CITY OR TOWN<br><b>Balto.</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  | 13e. STREET ADDRESS / ZIP CODE<br><b>5435 Bucknell Rd. 21206</b>                     |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Edwin Morphet</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Grace</b>   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>216-12-2406</b>  |  | 17. INFORMANT ADDRESS<br><b>Walter E. Graham 5435 Bucknell Rd. 21206</b>             |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESP. ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>CVA</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>MULT. MYELOMA</b><br>APLASIA  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 min.</b><br><b>12 hrs.</b><br><b>1 yr</b>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>APLASIA</b>  |  |   |  |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                   |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |
| 22a. I certify that (this hospital) attended the deceased from <b>Oct 2, 19 84</b> to <b>Nov 23, 19 84</b> , that (we) lost saw the deceased alive on <b>Nov 23, 19 84</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death. |  |   |  |  |   |
| 22b. SIGNATURE<br><b>Mark Kozak</b>  |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>11/23/84</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARK KOZAK</b>   |  | 22e. ADDRESS<br><b>JHH 600. N. wolfe St</b>   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11-27-84</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cem.</b>                                       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>John C. Miller Inc.</b>   |  | ADDRESS<br><b>6415 Belair Rd.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 26 1984</b>                                  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>  |

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then it should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, the medical examiner must be notified at once.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 8 5 5

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Anthony V. Grande</b>   |  |  | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>2</b> YEAR <b>84</b> |   |  | 2b. HOUR<br><b>11:00 AM</b>   |   |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>5</b> DAY <b>16</b> YEAR <b>25</b>   |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>59</b>  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4346 Nicholas Ave. 21206</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Bartender</b>  |   |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Lafontaine Blue</b>  |  |  |  |   |  |   |   |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>-</b>  |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |   |
| 13e. STREET ADDRESS / ZIP CODE<br><b>4346 Nicholas Ave. 21206</b>  |  |  |  |   |  |   |   |
| 14. FATHER'S NAME<br>FIRST <b>Michael</b> MIDDLE <b>Grande</b> LAST <b>Grande</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Jenny</b> MIDDLE <b>Del Sordo</b> LAST <b>Del Sordo</b>  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>219-14-2036</b>   |  | 17. INFORMANT<br>ADDRESS <b>Carolyn Grande 4346 Nicholas Ave.</b>   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>myocardial infarction.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>atrial fibrillation arrhythmia.</b>   |  |  |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>atrial fibrillation arrhythmia.</b>  |  |  |  |   |  |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19 <b>84</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/15</b> , 19 <b>84</b> , to <b>10/1</b> , 19 <b>84</b> , that (I) <b>we</b> lost<br>saw the deceased alive on <b>10/29</b> , 19 <b>84</b> , and that in (my) <b>our</b> opinion death occurred on the date and hour and from the causes stated<br>above, (I) <b>we</b> did (did not) view the body after death. |  |  |  |   |  |   |   |
| 22b. SIGNATURE<br><b>Jeffrey A. Cool</b>   |  | DEGREE<br><b>M.D.</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>10/2/84</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Jeffrey A. Cool</b>  |  | 22e. ADDRESS<br><b>Union Memorial Hosp.</b>  |  |   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>   |  | 23b. DATE<br><b>11-5-84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer</b>  |  | 23d. LOCATION<br>CITY OR TOWN <b>Balto.</b> COUNTY <b>Md.</b> STATE <b>Md.</b>  |   |
| 24. FUNERAL DIRECTOR<br>NAME <b>Schimunek Funeral Home, Inc. 21213</b> ADDRESS <b>3331 Brehms Lane</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 9 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John L. Davidson</b>   |   |

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 8 5 6

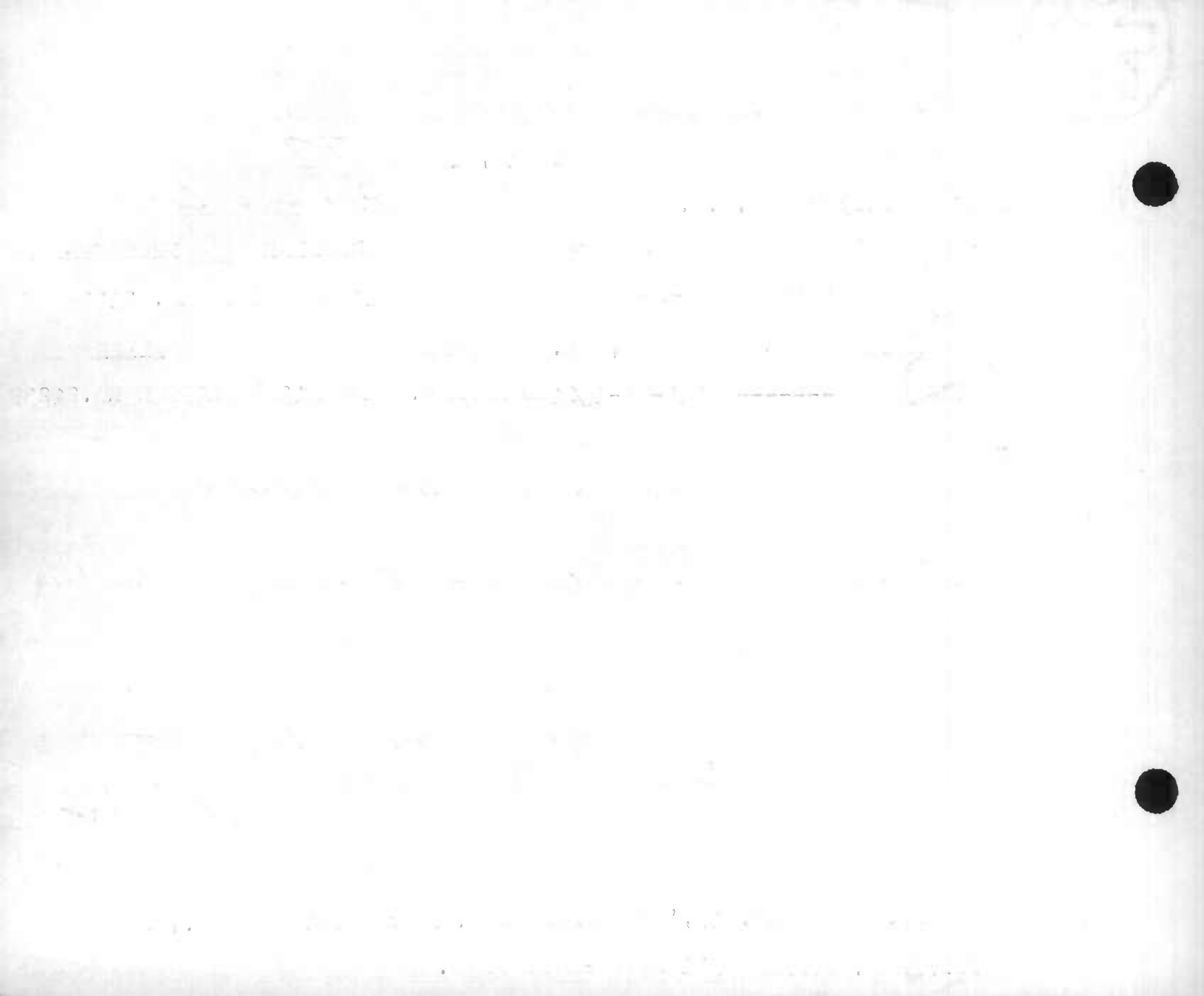
REG. NO.

|  |  |   |  |   |   |   |  |  |  |  |  |
|--|--|---|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Rufus JEFFERSON Graves</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 13 84</b>                 |   | 2b. HOUR<br><b>9:48 PM</b>                                      |   |  |  |  |  |  |
| 3. SEX<br><b>male</b>  |  | 4. RACE<br><b>white</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JULY 18, 1907</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |  | 8. IF UNDER 24 HRS.<br>HOURS MIN.                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NORTH CAROLINA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Good Samaritan Hospital</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SUPPLIER</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>PHOTOGRAPHIC</b>   |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  |   |  | 13b. CITY OR TOWN<br><b>Baltimore</b>   |   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13d. STREET ADDRESS / ZIP CODE<br><b>1304 CROFTON RD. 21239</b>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>RUFUS J. GRAVES, SR.</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>HATTIE ALLEN</b>  |   |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>212-03-1521</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>ROSALIE A. GRAVES 1304 CROFTON RD. 21239</b>   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Chronic Obstructive Pulmonary Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Left Middle Cerebral Artery Occlusion, Chronic Congestive Heart Failure</b>  |  |   |  |   |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/1</b> , 19 <b>84</b> , to <b>11/6</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>11/6</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                 |  |   |  |   |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Tom Tentel</b>  |  |   |  |   |   | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/13/84</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (Last, First, Middle)<br><b>Tom Tentel</b>   |  |   |  |   |   | 22e. ADDRESS<br><b>22. S. Greene St. Baltimore Md 21201</b>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  |   | 23b. DATE<br><b>NOV. 17, '84</b>                                       |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MORELAND MEM. PARK</b> |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE CO., MD</b>   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>WILLIAM E. JOHNSON</b>  |  |   |  |   |   | ADDRESS<br><b>8521 LOCH RAVEN BLVD.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 16 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson Rendell</b> |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Item 13e per phone 12/4/84 dad

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 8 5 7

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |  |  |  |  |   |  |  |
|---|--|--|--|---|--|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>LOUISE MARIAN GRAY</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-28-84</b>                 |   | 2b. HOUR<br>MIN.<br><b>15<sup>55</sup> A M</b>                                       |  |  |  |   |  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>07/23/21</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><b>63</b>                               |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>balto city</b> MD.                      |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST AGNES</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>NURSE</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>HOSPITAL</b>             |   |  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS, ZIP CODE<br><b>Apt. 5 H 820 Penrose Pl. Caton Avenue Baltimore, Maryland 21229</b> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>David Gray</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ollie Williams</b> |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No.</b> |  |  |   | 16b. SOCIAL SECURITY NO.<br><b>217-22-9155</b> |  |
| 17. INFORMANT<br><b>Lloyd P. Gray</b>   |  |  | ADDRESS<br><b>12 South Culver Street Baltimore, Maryland 21229</b>     |   |  |  |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cirrhosis Liver</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____                    |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-21</b> , 19 <b>84</b> , to <b>11-28</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>11-28</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Kennerth Williams</b>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |  |  | 22c. DATE SIGNED<br><b>11-28-84</b>                              |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Kennerth Williams</b>   |  |  |  | 22e. ADDRESS<br><b>Saw Agnes Hospital</b>   |  |  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>12/2/1984</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Memorial Park</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>           |  |  |   |  |  |
| 24. FUNERAL DIRECTOR'S NAME<br><b>Nutter &amp; Sons</b>   |  |  |  | 24b. ADDRESS<br><b>2501 Gwynns Falls Parkway</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 30 1984</b>                                |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>      |   |  |  |
| Funeral Home Inc. Baltimore, Maryland 21216   |  |  |  |   |  |  |  |  |   |  |  |

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VIRGINIA

U. S. A.

MARYLAND

BALTIMORE

DAVID

GRAY

Office

No.

217-22-015

1100 E. Gray

12 South Calver Street  
Baltimore, Maryland 21204

BALTIMORE, MARYLAND 21204  
J. F. H. [illegible]  
[illegible]

Baltimore, Maryland

19/2/1984

Unit 1

General Home Inc. Baltimore, Maryland 21218  
Walter & Sons 2201 Gaynes & Co. Baltimore



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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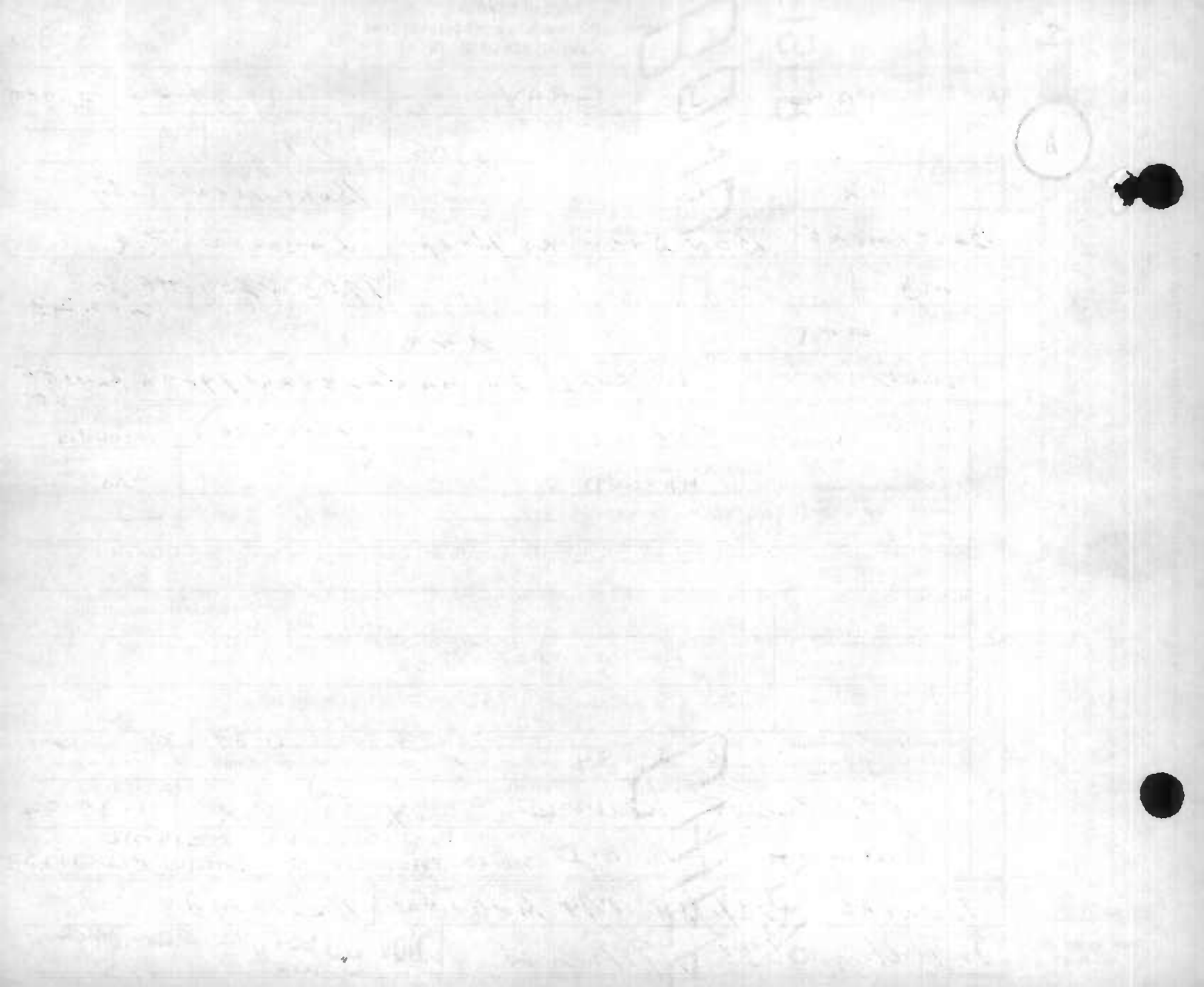
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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |   |  |   |  |
|--|--|---|--|--|--|---|--|---|--|
| 1- FOR<br>STATE<br>REGISTRAR   |  | 8 4 2 9 8 5 8   |  |  |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>PAUL J. GRAY</b>  |  |   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>11-29-84</b>                |   |  | 2b. HOUR<br><b>3:49 PM</b>  |  |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>B</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>10 16 05</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BON SECOURS Hosp.</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>LABORER</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>R.R.</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b>   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>1903 W. Bayonne St 21223</b>   |  |
| 14. FATHER'S NAME<br>FIRST <b>Wm</b> MIDDLE <b>R</b> LAST  |  |   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Anna</b> MIDDLE <b>R</b> LAST |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>240-18-5553</b>  |  | 17. INFORMANT ADDRESS<br><b>Emma Hansen 1903 W. Bayonne St</b>   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest (Aortic → V. Fib → EM Disc.)</b>   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>minutes</b>   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>HASCVD</b>  |  |   |  |  |  |   |  | <b>Yrs</b>  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |   |  |  |  |   |  | _____   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10-2-84</b> to <b>11-29-84</b> , that (I) (we) saw the deceased alive on <b>10-2-84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>William R. Law</b>  |  | DEGREE<br><b>MD</b>   |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11-29-84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>WILLIAM R. LAW MD</b>  |  | 22e. ADDRESS<br><b>BON SECOURS HOSPITAL 2000 LO. BALTIMORE ST BALTO. MD 21223</b>   |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE)<br><b>Burial</b>   |  | 23b. DATE<br><b>12/1/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt Auburn</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD</b>   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>John W. Hays</b> ADDRESS <b>638 N. 7th St</b>  |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 29 1984</b>   |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) and 3 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |  |  | 8 4 2 9 8 5 9  |  |
|--|--|---|--|---|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR   |  |   |  |   |  |  |  |  |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Doris G. Green  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11/11/84   |  |  |  | 2b. HOUR<br>10 <sup>12</sup> M   |  |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 28 1918   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>66 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U S A   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore city MD.   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Sinai Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. STATE<br>Md   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br>3900 Fordleigh Road 21215                          |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Griffin   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Carrie Ailor   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  |   |  | 16b. SOCIAL SECURITY NO<br>215-12-5122  |  | 17. INFORMANT ADDRESS<br>Sandra Dow 3900 Fordleigh Road  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardio pulmonary Arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Metastatic Adeno carcinoma<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Lung carcinoma (? Adeno)                        |  |   |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Sudden |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/7 1984, to 11/11 1984, that (I) (we) last saw the deceased alive on 11/11/84 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>Donald H. Lange MD   |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  | 22c. DATE SIGNED<br>11/11/84                           |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  |   |  | 22e. ADDRESS   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |   |  | 23b. DATE<br>11/15/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Garrison Forest VA   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Owings Mills Md                        |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>William C. March F/H 1101 E. North Ave   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 13 1984   |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Rendell                                 |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR<br>1. STATE<br>REGISTRAR   |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 4 2 9 8 6 0<br>REG. NO.   |  |   |  |
|--|--|--|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>MARIE French GREEN  |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 25 84   |  |   |  | 2b. HOUR<br>10 M  |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>BLACK   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 10 04   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE<br>(COUNTRY)<br>Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore MD.   |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>LUTHERAN Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Nurse                       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Nursing Home   |  |   |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>25 N. Monastery Avenue   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Henry French   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mamie Collins  |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  |  |  | 16b. SOCIAL SECURITY NO.<br>215-24-3548   |  | 17. INFORMANT<br>ADDRESS<br>Mr. Willie French, Jr., Baltimore, MD                               |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiac shock.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Acute MI.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a<br>cardiac arrhythmias   |  |  |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost<br>saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br>Bach T Duong M.D.  |  |  |  |   |  | DEGREE<br>M.D.  |  | ATTENDING<br>PHYSICIAN <input type="checkbox"/> MEDICAL<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>11/25/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>BACH T DUONG  |  |  |  |   |  | 22e. ADDRESS<br>LUTHERAN HOSPITAL   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |  |  | 23b. DATE<br>Nov. 29, 1984  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>French Fam. Cem.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Warrenton, Virginia   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>JOYNES FUNERAL HOME  |  |  |  |   |  | ADDRESS<br>35 N 3rd St.<br>Warrenton, VA  |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 07 1984  |  |   |  |

MEDICAL CERTIFICATION

|           |           |       |                        |
|-----------|-----------|-------|------------------------|
| Henry     | French    | Namie | Collins                |
| Maryland  | Baltimore | x     | 25 N. Monastery Avenue |
| Baltimore | U.S.      | x     | ----- Home             |
| Virginia  | U.S.      | x     | ----- Home             |

NO --- 615-54-54 AMT. Willie French, Jr., Baltimore, MD

Burial  
 1934  
 Nov. 29  
 French Rem. Cem.  
 Warrenton, Oregon  
 DEC 06 1981  
 35 N. 3rd St.  
 Warrenton, Oregon



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director. Page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, then item 18 should not be marked.

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |   |   |  |  |  |
|--|--|---|--|---|---|---|--|--|--|
| CERTIFICATE OF DEATH   |  |   |  |   |   |   |  |  |  |
| REG. NO. 8 4 2 9 8 6 1   |  |   |  |   |   |   |  |  |  |
| 1. FOR STATE REGISTRAR   |  |   |  |   |   |   |  |  |  |
| I. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>PAUL O. GREGOR  |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>11 13 84  |   | 2b. HOUR<br>1:30P AM   |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>9 22 1922  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>62 YRS.                                  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes Hospital |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Contractor |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Self-Emp.   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE CITY OR TOWN<br>Maryland Anne Arundel  |  |   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br>7231 Wright Rd. 21076  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Charles W. Gregor, Sr.  |  |   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Hedwig Krebs                                      |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>WW 2  |  | 17. INFORMANT ADDRESS<br>Catherine T. Gregor 7231 Wright Rd.<br>Hanover, Md. 21076  |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>intracranial hemorrhage</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>hypertension</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |  |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |   |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11-12</u> , 19 <u>84</u> , to <u>11-13</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>11-13</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |   |   |  |  |  |
| 22b. SIGNATURE <u>Kenneth Williams</u> M.D. DEGREE   |  |   |  |   | 22c. DATE SIGNED <u>11-13-84</u>  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Kenneth Williams</u>   |  |   |  |   | 22e. ADDRESS<br><u>St. Agnes Hospital</u>   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>11/16/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Mem. Prk.   |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Elkridge Howard Maryland         |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Gary L. Kaufman Funeral Home  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 15 1984  |   | 25b. REGISTRAR'S SIGNATURE   |  |  |
| ADDRESS<br>Elkridge, Maryland  |  |   |  |   |   |   |  |  |  |

MEDICAL CERTIFICATION



|    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |     |
|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|
| 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 | 41 | 42 | 43 | 44 | 45 | 46 | 47 | 48 | 49 | 50 | 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 | 61 | 62 | 63 | 64 | 65 | 66 | 67 | 68 | 69 | 70 | 71 | 72 | 73 | 74 | 75 | 76 | 77 | 78 | 79 | 80 | 81 | 82 | 83 | 84 | 85 | 86 | 87 | 88 | 89 | 90 | 91 | 92 | 93 | 94 | 95 | 96 | 97 | 98 | 99 | 100 |
| 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 | 41 | 42 | 43 | 44 | 45 | 46 | 47 | 48 | 49 | 50 | 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 | 61 | 62 | 63 | 64 | 65 | 66 | 67 | 68 | 69 | 70 | 71 | 72 | 73 | 74 | 75 | 76 | 77 | 78 | 79 | 80 | 81 | 82 | 83 | 84 | 85 | 86 | 87 | 88 | 89 | 90 | 91 | 92 | 93 | 94 | 95 | 96 | 97 | 98 | 99 | 100 |

11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 8 6 2

1- FOR  
STATE  
REGISTRAR

REG. NO.

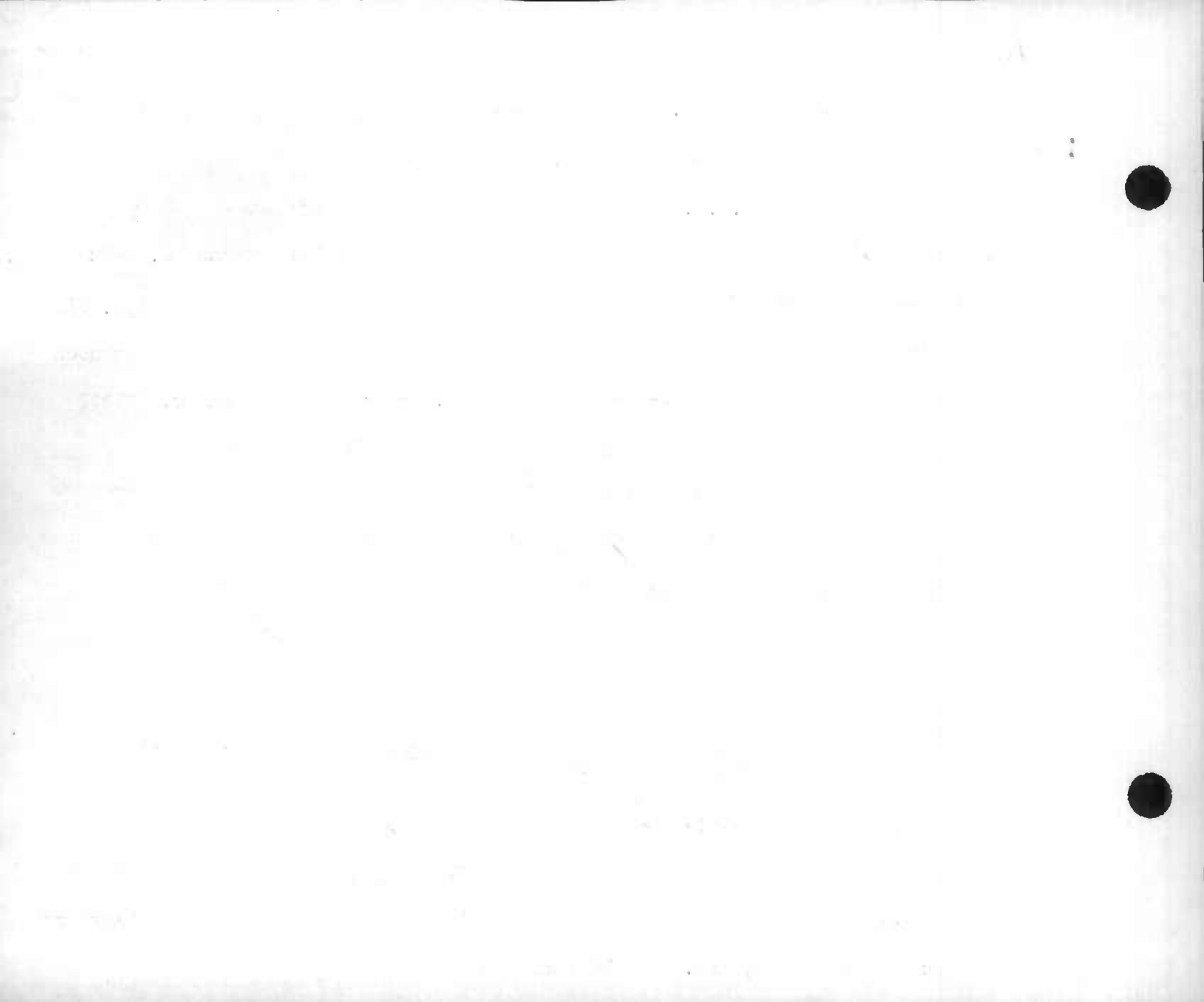
|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>OLLIE M. GREGORY</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 11 84</b> |   |  | 2b. HOUR<br>M<br><b>8 PM</b>   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 23 1897</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto Md</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Meridian Cotton Manor</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Machine Foreman</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>J. Smith &amp; Co.</b>   |  |
| 13a. STATE<br><b>Maryland</b>  |  |   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Arbutus</b>  |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>3300 Benson Avenue Apt. #123 21227</b>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Gregory</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Josephine Unknown</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>212-07-7592</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Lloyd F. Fromm 2204 Gaylawn Dr. 21227</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ruptured Abdominal aorta Artery</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Aneurysm Aorta</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Arteriosclerotic CV Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Craniotomy</b> |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Diabetes mellitus (adult onset) Chronic Obstructive Lung Disease</b>  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 1974</b> to <b>10 Oct 1984</b> , that (I) (we) last saw the deceased alive on <b>Oct 10 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Alejandro Mejia MD</b><br>THE PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED   |  |
| 22d. ADDRESS<br><b>405 Frederick Rd Catonsville 21228</b>  |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11/15/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Hubbard Funeral Home, Inc.</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 13 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be included by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows city injury, or other traumatic event, then medical examiner must be called about.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbonpapers, papers 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |  |                                    |  |   |  |  |
|--|--|--|--|--|------------------------------------|--|---|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  | 8 4 2 9 8 6 3                      |  |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  |  | 2a. DATE OF DEATH                  |  |   |  |  |
| WEBSTER Donald Griebel   |  |  |  |  | NOVEMBER 23, 1984                  |  |   |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |                                    | 6. AGE (IN YEARS (LAST BIRTHDAY))  |   | 7b. HOUR   |  |
| MALE   |  | CAUCASIAN  |  | 07/27/1916   |                                    | 68   |   | 12:45A.M.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH   |   |  |  |
| MARYLAND   |  | U.S.A.   |  |  |                                    | BALTIMORE CITY   |   | MD.  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |                                    | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |   | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| BALTIMORE  |  | SOUTH BALTIMORE GENERAL HOSPITAL   |  |  |                                    | NONE   |   | NONE   |  |
| 13a. STATE   |  |  | 13b. COUNTY                                      |  | 13c. CITY OR TOWN                  |  | 13d. STREET ADDRESS   |  |  |
| MARYLAND   |  |  | AA   |  | ANNAPOLIS                          |  | BAY MANOR NURSING HOME<br>509 REVELL HWY. ANNAPOLIS, MD. 21401      |  |  |
| 14. FATHER'S NAME  |  |  |  |  | 15. MOTHER'S MAIDEN NAME           |  |   |  |  |
| GREG WEBSTER W. Griebel  |  |  |  |  | ELIZABETH MYRTLE                   |  |   |  |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |  |  |  |  | 16b. SOCIAL SECURITY NO.           |  | 17. INFORMANT ADDRESS   |  |  |
| NO UNKNOWN NA  |  |  |  |  | 217-03-0390                        |  | T. S. SIDHU, MD. % SOUTH BALTIMORE GEN. HOSP. BALTIMORE. MD. 21230. |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:  |  |  |  |  |                                    |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY ARREST.</u>  |  |  |  |  |                                    |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |                                    |  |   |  |  |
| Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) <u>HYPOSTATIC PNEUMONIA</u>   |  |  |  |  |                                    |  |   |  | 10 DAYS.                                     |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>COLON CARCINOMA</u>  |  |  |  |  |                                    |  |   |  | 17 YEARS.                                    |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CHRONIC RENAL FAILURE, CHRONIC ANEMIA, ESOPHAGEAL STRICTURES,</u>  |  |  |  |  |                                    |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED |  |                                    | 20a. AUTOPSY?  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
| NONE   |  |  | NONE   |  |                                    | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY                              |  |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |  |
| N/A  |  |  | N/A  |  |                                    | N/A  |   |  |  |
| 21d. INJURY OCCURRED   |  |  | 21e. PLACE OF INJURY                             |  |                                    | 21f. LOCATION  |   |  |  |
| N/A  |  |  | N/A  |  |                                    | STREET CITY OR TOWN COUNTY STATE   |   |  |  |
| 22a. I certify that (if (this hospital) attended the deceased from <u>11/09/1984</u> , 19 <u>84</u> , to <u>11/23/</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>11/22/</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death. |  |  |  |  |                                    |  |   |  |  |
| 22b. SIGNATURE   |  |  |  |  | DEGREE                             |  |   | 22c. DATE SIGNED   |  |
| T. S. SIDHU  |  |  |  |  | MD                                 |  |   | 11/23/84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |  | 22e. ADDRESS                       |  |   |  |  |
| T. S. SIDHU  |  |  |  |  | % SOUTH BALTIMORE GEN. HOSPITAL    |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |  |   | 23d. LOCATION  |  |
| Burial   |  |  | 24 Nov. 1984                                     |  | Glen Haven Mem Pk.                 |  |   | Glen Burnie AA MD  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR      |  | 25b. REGISTRAR'S SIGNATURE  |  |  |
| Singleton Funeral Home, Glen Burnie, MD  |  |  |  |  | NOV 27 1984                        |  | [Signature]   |  |  |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHAM - 16 50M 4/83  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |                              |   |  |   |   |  |  | 8 4 2 9 8 6 4  |  |
|--|--|---|------------------------------|---|--|---|---|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO.  |                              |   |  |   |   |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Oliver H. B. Griffin</b>  |  |   |                              |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 21 84</b>                       |   |   | 2b. HOUR<br><b>11 25</b> M   |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b>   |                              | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>NOV- 27 1907</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |  | 8. IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 9a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 9b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                              | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Providence Hospital</b> |                              |   |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>laborer</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Copper company</b>   |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |                              | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br><b>2300 Ellamont Street 21216</b>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Oliver H. B. Griffin</b>  |  |   |                              |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Florence Williams</b>    |   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>yes</b>  |  |   |                              |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>16-07-0739</b> |   | 17. INFORMANT<br>ADDRESS<br><b>Oliver W. Griffin Phila. Pa.</b> |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio-Pulmonary Arrest</b>   |  |   |                              |   |  |   |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>10-15 minutes</b>  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Presumed Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |                              |   |  |   |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)   |  |   |                              |   |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |                              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   |                              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/21/84</b> , 19 <b>84</b> , to <b>11/21</b> , 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>11/21</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |                              |   |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Clarence Smith MD</b>   |  |   |                              | DEGREE  |  |   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/21/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Clarence Smith</b>   |  |   |                              | 22e. ADDRESS<br><b>2800 Liberty Heights Ave</b>   |  |   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>11-27-84</b> |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Carroll's Forest Cemetery</b>       |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co. Md.</b>   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Nutter &amp; Sons Funeral Home</b>  |  |   |                              | ADDRESS<br><b>2301 Guyton Park</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 23 1984</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>   |  |  |  |

MEDICAL CERTIFICATION



RECEIVED  
FEB 19 1941

RECEIVED  
FEB 19 1941

Office of the  
Director of the  
Bureau of the  
Census

Washington, D.C.

February 19, 1941  
Mr. J. Edgar Hoover  
Director  
Federal Bureau of Investigation  
Washington, D.C.

Dear Mr. Hoover:

I am writing you in regard to the  
information which you have  
furnished me regarding the  
activities of the  
German-Italian Axis  
in the United States.

I am very interested in the  
information which you have  
furnished me regarding the  
activities of the  
German-Italian Axis  
in the United States.

Very truly yours,  
Walter Dill Scott  
Director of the  
Bureau of the  
Census

Enclosed for you are  
three copies of a  
report on the  
activities of the  
German-Italian Axis  
in the United States.



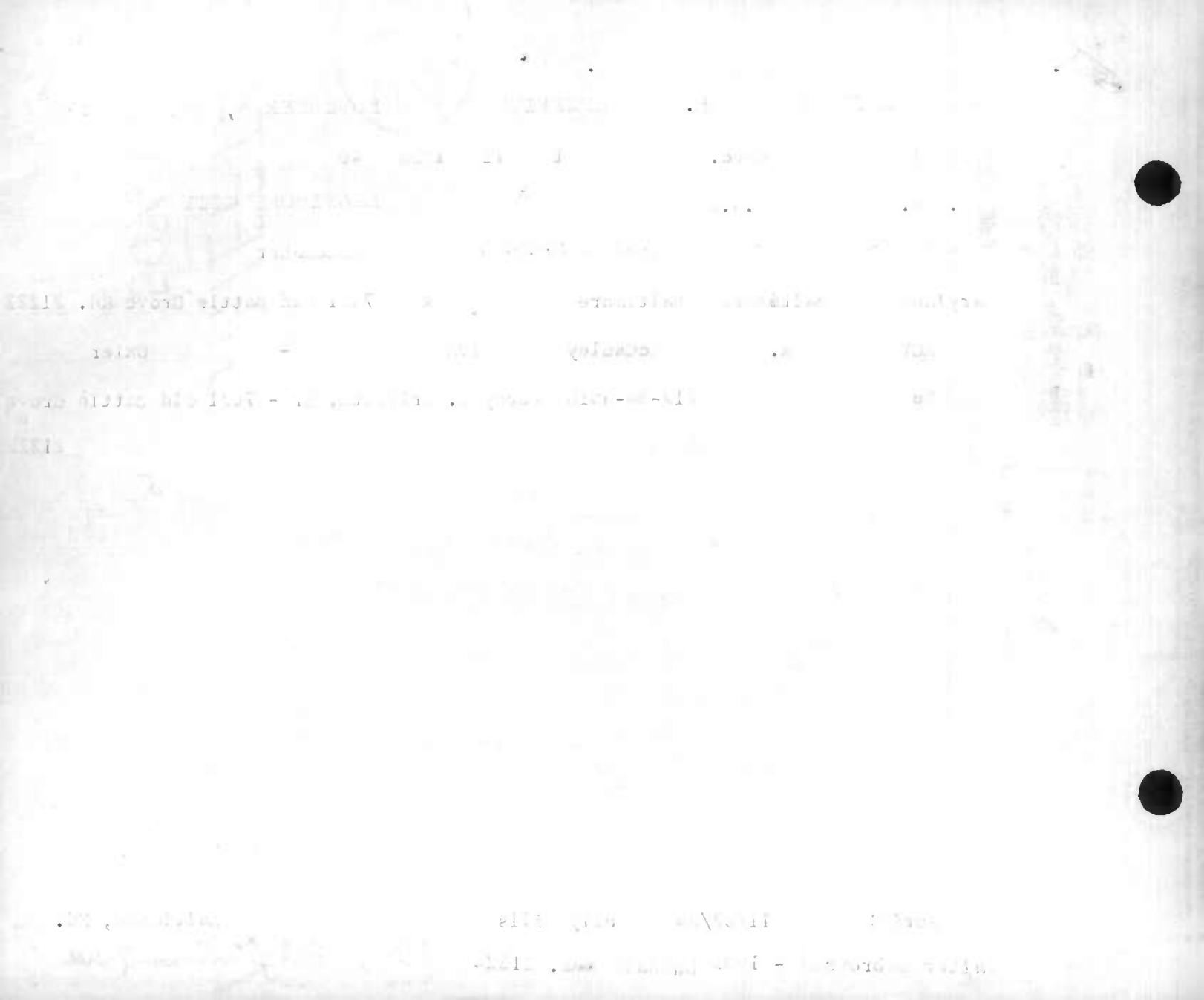
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be signed by the funeral director. Page 1 should be detached for use as the burial-transit permit. Then please remove carbonized copy of this certificate and forward it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. Page 2 should be retained by the funeral director. Page 3 should be retained by the funeral director. Page 4 should be retained by the funeral director.

IMPORTANT: If item 21 is marked or item 18 is marked, the death certificate must be signed by the attending physician and the funeral director.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 4 2 9 8 6 5   |  |  |  |  |  |
|---|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.  |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>BARBARA M. GRIFFITH</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 4, 1984</b>  |  | 2b. HOUR<br>A M<br><b>7:20 A</b>   |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Cauc.</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 11 1938</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>46</b>         |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>W. Va.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.        |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b>  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. CITY OR TOWN<br><b>Baltimore</b>   |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13d. STREET ADDRESS / ZIP CODE<br><b>7631 Old Battle Grove Rd. 21222</b> |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ACY R. McCauley</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>IVA - Oxier</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>212-34-4518</b>                           |  |  |  |
| 17. INFORMANT<br><b>Leroy E. Griffith, Sr - 7631 Old Battle Grove Rd.</b>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>SEPSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>NECROTIZING PNEUMONIA</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 min 21222</b><br><b>5 days</b><br><b>2 weeks</b> |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>HEPATIC FAILURE DISSEMINATED INTRAVASCULAR COAGULATION</b> |  | 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19               |  |  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  | 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                        |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>October 22, 1984</b> , to <b>November 4, 1984</b> , that (I) (we) lost saw the deceased alive on <b>November 4, 1984</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. |  |   |  | 22b. SIGNATURE<br><b>Kenneth J. Holroyd</b><br>DEGREE   |  | 22c. DATE SIGNED<br><b>11-4-84</b>                                       |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KENNETH J. HOLROYD</b>  |  |   |  | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL</b>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11/07/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holly Hills</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>      |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Walter Dabrowski - 1005 Dundalk Ave. 21224</b>   |  |   |  | 25. DATE REC'D. BY REGISTRAR / REGISTRAR'S SIGNATURE<br><b>NOV 09 1984</b><br><b>John Davidson-Randall</b>  |  |  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 8 6 6

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |   |                            |   |
|--|--|--|---|---|----------------------------|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JOHN HENRY GRIGGS</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 26, 84</b> |   | 2b. HOUR<br><b>3:04P M</b> |   |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 7 22</b>  |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b> YRS.                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD. |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VA MEDICAL CENTER BALTIMORE MD</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |                            | 12b. KIND OF BUSINESS OR INDUSTRY                                 |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                            | 13. STREET ADDRESS + ZIP CODE<br><b>428 Old Town Mall 21202</b>   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Griggs</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                 |   |                            |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>217 20 6166</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Troy Houston 130 N. Aisquith St.</b>   |                            |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hemorrhage from esophageal varices</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Cirrhosis of Liver</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Alcoholism</b>   |  |  |   |   |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |   |   |                            |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                            |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |   |   |                            |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |                            |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                            |   |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>November 2, 19 84</b> to <b>November 26, 19 84</b> , that <input checked="" type="checkbox"/> (we) lost<br>saw the deceased alive on <b>November 26, 19 84</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated<br>above <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> view the body after death. |  |  |   |   |                            |   |
| 22b. SIGNATURE<br><b>Deborah Zimmerman</b> DEGREE  |  |  |   | 22c. DATE SIGNED<br><b>1/28/84</b>  |                            |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Deborah Zimmerman</b>  |  |  |   | 22e. ADDRESS<br><b>3900 Loch Raven Blvd. Baltimore MD 21218</b>   |                            |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>12/3/84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Forest VA</b>   |                            |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Owings Mills MD</b>   |  |  |   |   |                            |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H 1101 E. North Ave.</b>   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 29 1984</b>   |                            |   |
|  |  |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |                            |   |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 8 6 7

REG. NO.

FOR  
STATE  
REGISTRAR

|   |  |  |  |   |  |  |   |  |  |  |  |
|---|--|--|--|---|--|--|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>EVA GROSS</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 30 84</b> |   |  | 2b. HOUR<br><b>602</b> <small>g.m.</small>   |   |  |  |  |  |
| 3. SEX<br><b>F</b> FEMALE   |  | 4. RACE<br><b>C</b> CAUCASIAN  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 05 1906</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> <del>78</del> YRS.                      |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD                     |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>              |  |  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>4211 LABYRINTH RD. #21215</b> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>GERSHON FRIEMAN</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MINNIE UNKNOWN</b>  |  |  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b> |  |  | 16b. SOCIAL SECURITY NO.<br><b>218-32-5177B</b>        |   | 17. INFORMANT<br><b>MELVIN GROSS</b><br><b>4211 LABYRINTH RD. BALTO., MD 21215</b> |  |   |  |  |  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**Cardiorespiratory arrest**

DUE TO, OR AS A CONSEQUENCE OF

(b)

**AFIB CHF V Tsch**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11 19</b> , 19 <b>84</b> , to <b>11 30</b> , 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>11 30</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Speer MD</b>   |  |  |  | DEGREE<br><b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11-30-84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>David G. Spear</b>  |  |  |  | 22e. ADDRESS<br><b>Sinai Hosp Balt</b>   |  |   |  |

|  |  |                                  |  |   |  |   |  |
|--|--|----------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>   |  | 23b. DATE<br><b>DEC. 2, 1984</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WORKMEN CIRCLE</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b> |  |                                  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 7 1984</b>          |  | 25b. REGISTRAR'S SIGNATURE  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

GROSS, EVA  
608549 S3068 MED S  
11/19/84 K. GLICK  
7 SUDBROOK RD  
21215 F12/07 079547

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 8 6 8

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>BABY</b>            |  | FIRST MIDDLE LAST <b>GROSSMAN</b>  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>11 5 84</b>  |  | 2b. HOUR <b>54</b><br>MIN <b>10 AM</b>                         |  |
| 3. SEX <b>MALE</b>   |  | 4. RACE <b>CAUCASIAN</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>11 5 84</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>YRS.</b>                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD. |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SOUTH BALTIMORE GENERAL HOSPITAL</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| 13a. STATE <b>MD</b>                                       |  | 13b. COUNTY <b>Baltimore</b>   |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE <b>941 May Adon Cb. 21225</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>ARTHUR MATTHEWS</b> |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>JANET GROSSMAN</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.                                       |  |
| 17. INFORMANT  |  | ADDRESS  |  |  |  |  |  |

|  |  |   |  |
|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>25 min</b> |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.                                 |  | (b) <b>Prematurity</b>  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  | (c)   |  |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 5, 1984</b> to <b>Nov 5, 1984</b> (not (I) (we) lost saw the deceased alive on <b>Nov 5, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE <b>Lawrence S Schieken</b>  |  | DEGREE <b>MD</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED <b>11/5/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LAURENCE S SCHIEKEN</b>   |  | 22e. ADDRESS <b>South Baltimore Gen Hosp</b>                        |  |  |  |   |  |

|  |  |                          |  |                                    |  |   |  |
|--|--|--------------------------|--|------------------------------------|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b> |  | 23b. DATE <b>11/8/84</b> |  | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION CITY OR TOWN COUNTY STATE |  |
|--|--|--------------------------|--|------------------------------------|--|---|--|

|  |  |                            |  |  |  |   |  |
|--|--|----------------------------|--|--|--|---|--|
| 24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b> |  | ADDRESS <b>Balto., Md.</b> |  | 25a. DATE REC'D. BY REGISTRAR <b>NOV 09 1984</b> |  | 25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b> |  |
|--|--|----------------------------|--|--|--|---|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 27 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.





CHILLYN

80% COTTON



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 8 6 9

REG. NO.

|  |  |   |  |   |   |
|--|--|---|--|---|---|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 2a. DATE OF DEATH   |  | 2b. HOUR  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Jeanette M Gueydan</i>  |  | MONTH DAY YEAR<br><i>11 26 84</i>   |  | 10:05 PM  |   |
| 3. SEX<br><i>Female</i>  | 4. RACE<br><i>White</i>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>July 13, 1905</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>79</i> YRS.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>   | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                               |   |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Mercy Hospital</i> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Housewife</i> |   | 12b. KIND OF BUSINESS OR INDUSTRY                     |
| 13a. STATE<br><i>Maryland</i>  |  | 13b. COUNTY   | 13c. CITY OR TOWN<br><i>Baltimore</i>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><i>524 N. Charles St 21201</i> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Louis Thilmany</i>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Catherine Butz</i>  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>No</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>212-28-8132,</i>   |  | 17. INFORMANT ADDRESS<br><i>Carolyn A Houk 2109 B Town Hill Rd 21234</i>                        |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Bradycardia</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>myocardial Infarction</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |  |   |  |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)       |  |   |   |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11/25</i> , 19 <i>84</i> , to <i>11/26</i> , 19 <i>84</i> , that (I) (we) lost saw the deceased alive on <i>11/26</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.    |  |   |  |   |   |
| 22b. SIGNATURE<br><i>Dana S. Simpler</i>   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><i>11/26/84</i>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>DANA SIMPLER</i>   |  | 22e. ADDRESS<br><i>MERCY HOSPITAL</i>   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>11/29/84</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Gardens Of Faith</i>                                   |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore, Maryland</i>   |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Leonard J Ruck Inc. Baltimore, Maryland</i>  |  |   |   |
| 25a. DATE REC'D. BY REGISTRAR<br><i>NOV 28 1984</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Lelia Davidson-Randall</i>   |  |   |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 8 7 0

|  |  |   |  |
|--|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 7. REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>JOSEPH J. GUMBERT  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 / 04 / 84<br>2 <sup>nd</sup> P.M.   |  |
| 3. SEX<br>Male   | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3-8-1910  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                    | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE MD.  |  | 10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Ret. Real Estate  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL  |  | 12. KIND OF BUSINESS OR INDUSTRY<br>Amoco Oil Co.   |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore  |  |
| 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 13e. STREET ADDRESS / ZIP CODE<br>5916 Hillen Rd. 21239  |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joseph W. Gumbert   |  |
| 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna W. Luntz   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  |
| 16b. SOCIAL SECURITY NO.<br>212-03-1508  |  | 17. INFORMANT<br>Catherine Gumbert, Same as 13e   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Neuro Muscular Disease of unknown</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Etiology</u>          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Aspiration Pneumonia</u>   |  |   |  |
| 19a. DATE OF OPERATION<br>—  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>—                  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/04/84 to 11/04/84, that (I) (we) last saw the deceased alive on 11/04/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |
| 22b. SIGNATURE<br>SC Breg  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        | 22c. DATE SIGNED<br>11/4/84  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. TIMOTHY C. TRAGESER   |  | 22e. ADDRESS<br>UNION MEMORIAL HOSPITAL   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  | 23b. DATE<br>11-13-84  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto., Md.  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck, Inc., 5305 Harford Rd.  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 13 1984  |  |
| 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randall  |  |   |  |



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IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |                                    |  |   |   |                                 |  |  |
|---|--|---|--|---|------------------------------------|--|---|---|---------------------------------|--|--|
| CERTIFICATE OF DEATH  |  |   |  |   |                                    |  |   |   |                                 |  |  |
| REG. NO. 8 4 2 9 8 7 1  |  |   |  |   |                                    |  |   |   |                                 |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   | FIRST MIDDLE LAST  |   |                                    | 2a. DATE OF DEATH  |   | MONTH DAY YEAR  |                                 | 2b. HOUR                                     |  |
| FRANK   |  |   | GUNTHER JR   |   |                                    | 11 4 84  |   | 12:18 PM  |                                 |  |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |                                    | 6. AGE (IN YEARS LAST BIRTHDAY)  |   | IF UNDER 1 YEAR   |                                 | IF UNDER 24 HRS                              |  |
| Male  |  | White   |  | MONTH DAY YEAR<br>2 23 13   |                                    | 71 YRS.  |   | MONTHS DAYS   |                                 | HOURS MIN.                                   |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH   |   |   |                                 |  |  |
| Maryland  |  | U.S.A.  |  |   |                                    | Baltimore City MD  |   |   |                                 |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |                                    |  |   |   |                                 |  |  |
| Baltimore   |  | Francis Scott Key Medical Center  |  |   |                                    |  |   |   |                                 |  |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |                                    |  |   |   |                                 |  |  |
| Retired   |  | Union Chemical  |  |   |                                    |  |   |   |                                 |  |  |
| 13a. STATE  |  |   | 13b. COUNTY  |   | 13c. CITY OR TOWN                  |  | 13d. INSIDE CITY LIMITS?  |   | 13e. STREET ADDRESS / ZIP CODE  |  |  |
| Maryland  |  |   | ---  |   | Baltimore                          |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 910 South Highland Avenue 21224 |  |  |
| 14. FATHER'S NAME   |  |   | 15. MOTHER'S MAIDEN NAME   |   |                                    |  |   |   |                                 |  |  |
| FIRST MIDDLE LAST<br>Frank  |  |   | FIRST MIDDLE LAST<br>Guntner Sr.                                       |   |                                    | FIRST MIDDLE LAST<br>Johanna   |   |   |                                 |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)                |   |                                    | 17. INFORMANT ADDRESS  |   |   |                                 |  |  |
| No  |  |   | ---  |   |                                    | 212-03-1682 William R. Gunther 910 S. Highland Ave. 21224  |   |   |                                 |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:  |  |   |  |   |                                    |  |   |   |                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a) ISCHEMIC CARDIOMYOPATHY   |  |   |  |   |                                    |  |   |   |                                 | 2 yrs  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |                                    |  |   |   |                                 |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SMALL VESSEL DISEASE   |  |   |  |   |                                    |  |   |   |                                 | > 20 yrs                                     |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) SMOKING, DIABETES, & HYPERTENSION  |  |   |  |   |                                    |  |   |   |                                 | > 20 yrs                                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: END STAGE RENAL FAILURE, ISCHEMIC BOWEL, ISCHEMIC PERIPHERAL VASCULAR DISEASE  |  |   |  |   |                                    |  |   |   |                                 |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |                                    | 20a. AUTOPSY?  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |                                 |  |  |
|   |  |   |  |   |                                    | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                 |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |                                 |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |                                 |  |  |
|   |  |   |  |   |                                    |  |   |   |                                 |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from NOV 2, 19 84, to NOV 4, 19 84, that (I) (we) last saw the deceased alive on NOV 4, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |                                    |  |   |   |                                 |  |  |
| 22b. SIGNATURE  |  |   | DEGREE   |   |                                    | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   | 22c. DATE SIGNED                |  |  |
| Michael Soulen MD   |  |   |  |   |                                    |  |   |   | 11/4/84                         |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   | 22e. ADDRESS   |   |                                    |  |   |   |                                 |  |  |
| MICHAEL SOULEN MD   |  |   | 4140 EASTERN AVE. BALTIMORE MD 21224                                   |   |                                    |  |   |   |                                 |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |   | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |                                 |  |  |
| Burial  |  |   | 11-7-84  |   | Holly Hills Mem. Park              |  |   | Middle River Balto. Co., Md.  |                                 |  |  |
| 24. FUNERAL DIRECTOR  |  |   | 25a.   |   |                                    |  |   |   |                                 |  |  |
| NAME Charles S. Zeiler & Son Inc.   |  |   | ADDRESS 6224 Eastern Ave.  |   |                                    | 25b. NOV 07 1984 Julia Davidson-Randall  |   |   |                                 |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  | 8 4 2 9 8 7 2 |  |
|--|--|--|--|---|--|---|--|--|--|---------------|--|
| 1- FOR STATE REGISTRAR   |  |  |  |   |  |   |  |  |  | REG. NO.      |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>MARIE E. GUY</b>  |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>NOVEMBER 24, 1984</b>     |   |  | 2b. HOUR<br><b>8:25A M</b>   |  |               |  |
| 3. SEX<br><b>F</b>   |  | 4. RACE<br><b>W</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>MARCH 21, 1924</b>  |  | 6. AGE (IN YEARS) (LAST BIRTHDAY) YRS.<br><b>60</b>   |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                     |  |  |  |               |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOME MAKER</b>                    |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |               |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>          |  | 13e. STREET ADDRESS / ZIP CODE<br><b>2211 E. PAYETTE ST. 21231</b>   |  |               |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>George L. STINEBAUGH</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>EDITH CRAFT</b> |   |  |  |  |               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>217-18-3007</b>   |  | 17. INFORMANT ADDRESS<br><b>JEAN LEASURE 503 N. PORT ST</b>   |  |   |  |  |  |               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>POSSIBLE PANCREATIC CANCER</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |   |  |  |  |               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____   |  |  |  |   |  |   |  |  |  |               |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)   |  |   |  |  |  |               |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |               |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>NOVEMBER 22 19 84</b> to <b>NOVEMBER 24 19 84</b> , that (1) we last saw the deceased alive on <b>NOVEMBER 24 19 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) we (I) did (did not) view the body after death.   |  |  |  |   |  |   |  |  |  |               |  |
| 22b. SIGNATURE<br><i>Thomas G. Miller, MD.</i>   |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  |   |  | 22c. DATE SIGNED<br><b>11/24/84</b>  |  |               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>THOMAS G. MILLER, MD</b>   |  |  |  | 22e. ADDRESS<br><b>CHURCH HOSPITAL CORPORATION<br/>100 N. BROADWAY, BALTIMORE, MD. 21231</b>  |  |   |  |  |  |               |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>Nov 27, 1984</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MD</b>  |  |  |  |               |  |
| 24. FUNERAL DIRECTOR NAME<br><b>HARTLEY MILLER</b>   |  |  |  | ADDRESS<br><b>7527 HARFORD RD</b>   |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>NOV 26 1984 Julia Davidson-Randall</b> |  |  |  |               |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 4 2 9 8 7 3  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |  |   |
|---|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Joseph W Haddock Jr.</b>                 |  |   | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>23</b> YEAR <b>1984</b>                     |  | 2b. HOUR<br>M                                       |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH <b>1</b> DAY <b>9</b> YEAR <b>1917</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.           |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Rhode Island</b>                | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4620 Crosswood Rd.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret Salesman</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Grocers</b> |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |
| 14. FATHER'S NAME<br>FIRST <b>Joseph</b> MIDDLE <b>W</b> LAST <b>Haddock</b>    |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Eva</b> MIDDLE <b>Deane</b> LAST   |   | 13e. STREET ADDRESS / ZIP CODE<br><b>4620 Crosswood Ave 21214</b>                                |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>Yes</b> |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES) <b>WW11 037 01 2159</b>   |   | 17. INFORMANT<br><b>Joseph W. Haddock 3rd</b> ADDRESS <b>7013 Stone Mill P l Alexandria, Va.</b> |   |

|   |  |  |  |
|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute MI</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCD</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a<br><b>Diabetes Mellitus</b>  |  |  |  |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12</b> 19 <b>82</b> , to <b>11</b> 19 <b>88</b> , that (I) (we) last saw the deceased alive on <b>11/26/88</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br><b>Miriam L. Cohen MD</b>   |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Miriam L. Cohen MD</b>  |  | 22e. ADDRESS   |  |

|   |                                |   |  |
|---|--------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>                              | 23b. DATE<br><b>11/26/1984</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>                       | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY STATE <b>Md.</b> |
| 24. FUNERAL DIRECTOR<br>NAME <b>Mitchell-Wiedefeld</b> ADDRESS <b>Home 6500 York Rd</b> |                                | 25. DATE RECD. BY REGISTRAR <b>NOV 27 1984</b> REGISTRAR'S SIGNATURE <b>[Signature]</b> |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



RECEIVED  
JAN 11 1984  
FBI  
NEW YORK

TO : DIRECTOR, FBI  
FROM : SAC, NEW YORK  
SUBJECT: [Illegible]  
[Illegible text follows, appearing to be a memorandum format with various fields and lines of text.]

[Large block of illegible text, likely the body of a letter or report.]

11/11/84  
[Illegible text at the bottom of the page]

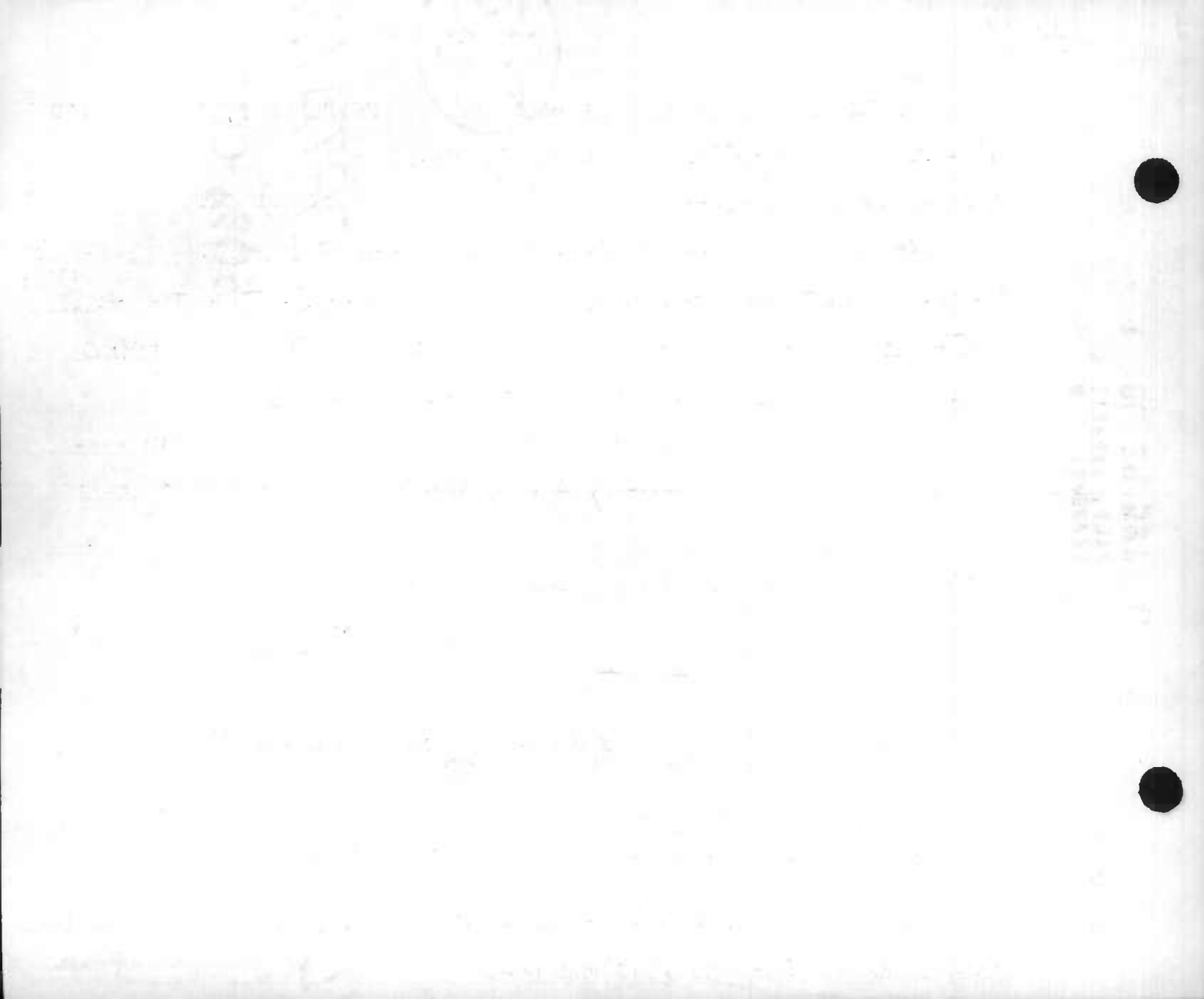
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 8 7 4

1 - STATE  
REGISTRAR

REG. NO.

|   |  |   |   |  |   |
|---|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>GARNETT A HALE</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 9, 1984</b>                              |  | 2b. HOUR<br><b>6:20</b> M   |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>DEC. 5, 1921</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b> YRS.                                    | 7. UNDER 1 YEAR<br>MONTHS DAYS<br><b>62</b>   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>AIR FORCE - RET.</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. GOV'T</b>  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>   |  |   | 13b. COUNTY<br><b>BALTIMORE</b>   | 13c. CITY OR TOWN<br><b>PARKVILLE</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JAMES A. HALE</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>NANNIE J. BYRO</b>                      |  |   |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>W.W.T. 222180208</b>  |   | 17. INFORMANT<br><b>FAMILY RECORDS</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Coronary Artery Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>8 years</b> |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>ONE HOUR</b>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>Hypercholesterolemia, h/o HTN, h/o cigarette Abuse</b>   |  |   |   |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5 November</b> 19 <b>84</b> , to <b>9 November</b> 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>9 November</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                  |  |   |   |  |   |
| 22b. SIGNATURE<br><b>RW Wilson MD</b>   |  | DEGREE  |   | 22c. DATE SIGNED<br><b>11/9/84</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Raymond W. Wilson, MD</b>   |  | 22e. ADDRESS<br><b>The Johns Hopkins Hospital</b>   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>Nov. 13, 1984</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>DULANEY VALLEY</b>                          |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>TIMONUM BALTO MARYLAND</b>   |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>EVANS CHAPLAIN OF CHIMES 2325 YORK ROAD</b>  |   |  |   |
| 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 16 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |   |  |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |  |   |  |   |  | 8 4 2 9 8 7 5  |  |  |  |
|--|--|---|--|---|--|---|--|---|--|--|--|--|--|
| CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |   |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Benzena Hall</b>   |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 13, 1984</b>                                 |  |   |  | 2b. HOUR<br><b>4:46P</b>   |  |  |  |
| 3. SEX<br><b>F</b>   |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 18 47</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>37</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>37</b>   |  | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>46 30</b>                     |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>SC</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |  | 13a. STREET ADDRESS / ZIP CODE<br><b>1706 W. Lanvale St. 21217</b>                              |  |   |  |  |  |  |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Benjamin Hall</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lilease Rogers</b>  |  |   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>N/A</b>   |  | 17. INFORMANT<br><b>Benjamin Hall</b>   |  | ADDRESS<br><b>Columbia, SC</b>  |  | 29203   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>HYPOVOLEMIA AND SEPTIC SHOCK DUE TO POST OPERATIVE</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>STATUS POST-RECENT LEFT NEPHRECTOMY FOR MARKED</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>ACUTE AND SUBACUTE LEFT INTERSTITIAL NEPHRITIS AND LEFT RENAL ABSCESS.</b> |  |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>HEMORRHAGE.</b> |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>11/13/84</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Nephrectomy for Pyonephrosis of left Kidney</b>  |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |  |  |  |  |
| 22a. I certify that (x) (this hospital) attended the deceased from <b>September 24, 19 84</b> , to <b>November 13, 19 84</b> , that (x) (we) last saw the deceased alive on <b>November 13, 19 84</b> , and that in (x) (our) opinion death occurred on the date and hour and from the causes stated above. (x) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>James L. Patrick</b>  |  |   |  | DEGREE<br><b>M.D.</b>   |  |   |  | 22c. DATE SIGNED<br><b>11/14/84</b>   |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>James L. Patrick</b>   |  |   |  | 22e. ADDRESS<br><b>C/O Maryland General Hospital</b>  |  |   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11/17/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Zion Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. MD</b>                                  |  |   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H, Inc.</b>  |  |   |  |   |  | ADDRESS<br><b>1101 E. North</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 20 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Jane Dawson-Namake</b>            |  |  |  |





RECEIVED

NOV 19 1964



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 8 7 6

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Edward NMN Hall</i>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>11 28 84</i> |   |  | 2b. HOUR<br>M<br><i>M</i>   |  |
| 1. SEX<br><i>male</i>  |  | 4. RACE<br><i>B</i>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>8 11 97</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>87</i> YRS.                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>MARYLAND</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD. |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Bon Secour Hospital</i> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                 |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <i>MD</i> 13a. COUNTY <i>A.A.</i> |  | 13b. CITY OR TOWN<br><i>LOTHIAN</i>   |  | 13c. STREET ADDRESS / ZIP CODE<br><i>40 Ark Road 20711</i>  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>CHARLES HALL</i>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>LOVENIA McGowan</i>   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>no</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>220-30-2260</i>  |  | 17. INFORMANT<br>ADDRESS <i>Lothain, Md. 20711</i><br><i>GERTRUDE GROSS 40 Ark Road</i>   |  |   |  |

|   |  |   |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Pulmonary Embolism</i> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Thrombophlebitis</i>   |  |   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Asper</i>  |  |   |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

*Bowel obstruction / severe chronic pulmonary*

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>10-31</i> , 19 <i>84</i> , to <i>11-28</i> , 19 <i>84</i> , that (I) (we) lost<br>the deceased alive on <i>11-28</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |

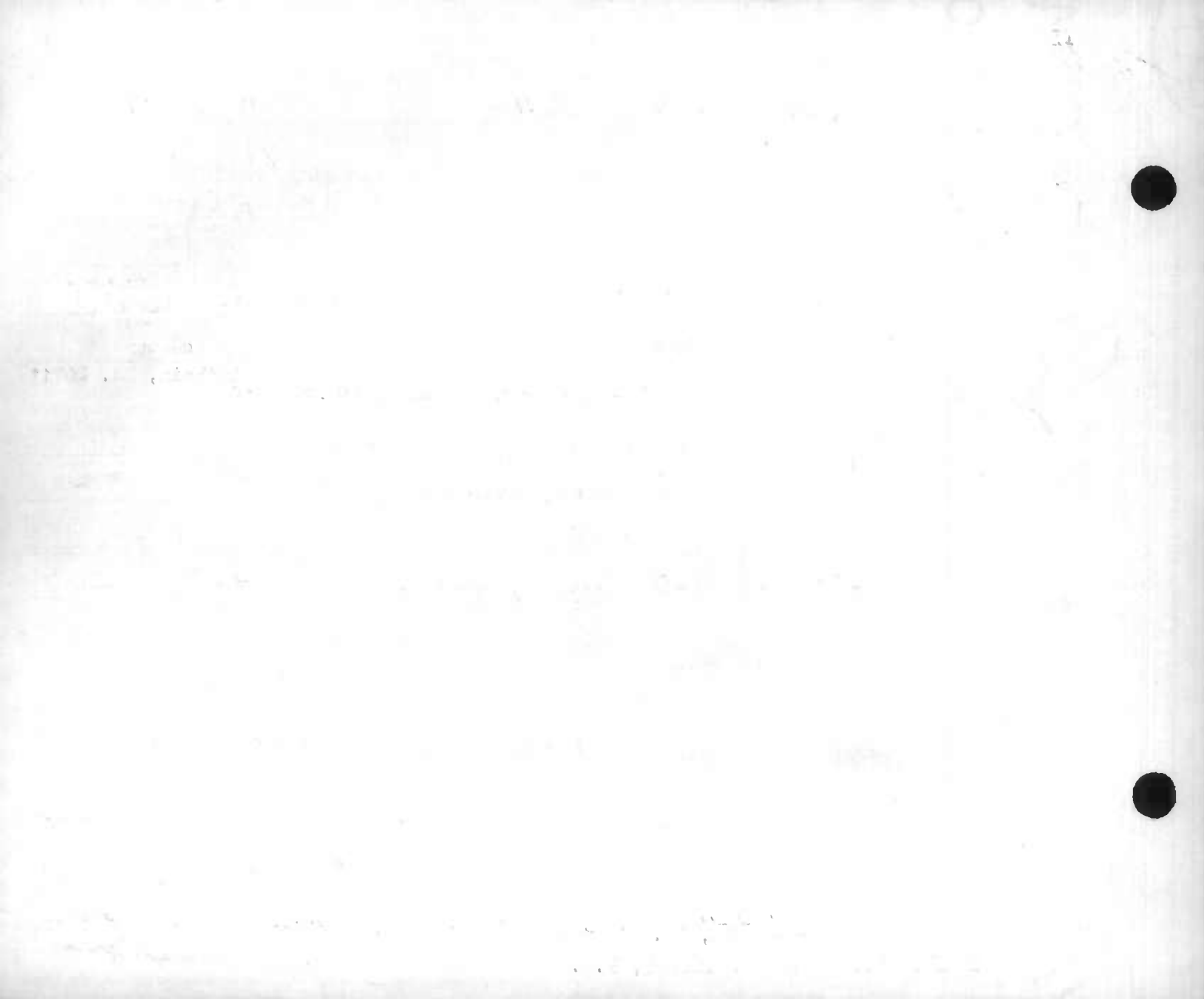
|   |  |  |  |  |  |                                     |  |
|---|--|--|--|--|--|-------------------------------------|--|
| 22b. SIGNATURE<br><i>M. J. Brown</i>                |  | DEGREE<br><i>MD</i>                              |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><i>11-29-84</i> |  |
| 22d. PHYSICIAN'S NAME (PRINT)<br><i>M. J. Brown</i> |  | 22e. ADDRESS<br><i>844 N. Carey Street 21217</i> |  |  |  |                                     |  |

|   |  |                               |  |   |  |  |  |
|---|--|-------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>BURIAL</i>                       |  | 23b. DATE<br><i>12-3-1984</i> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>MT. ZION CHURCH CEME</i> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Lothain A.A. Maryland</i> |  |
| 24. FUNERAL DIRECTOR<br>NAME <i>WILLIAM REESE &amp; SONS MORTUARY, P.A.</i> ADDRESS |  |                               |  | 25a. DATE REC'D. BY REGISTRAR<br><i>DEC 3 1984</i>                |  | 25b. REGISTRAR'S SIGNATURE<br><i>W. Davidson-Randall</i>                   |  |

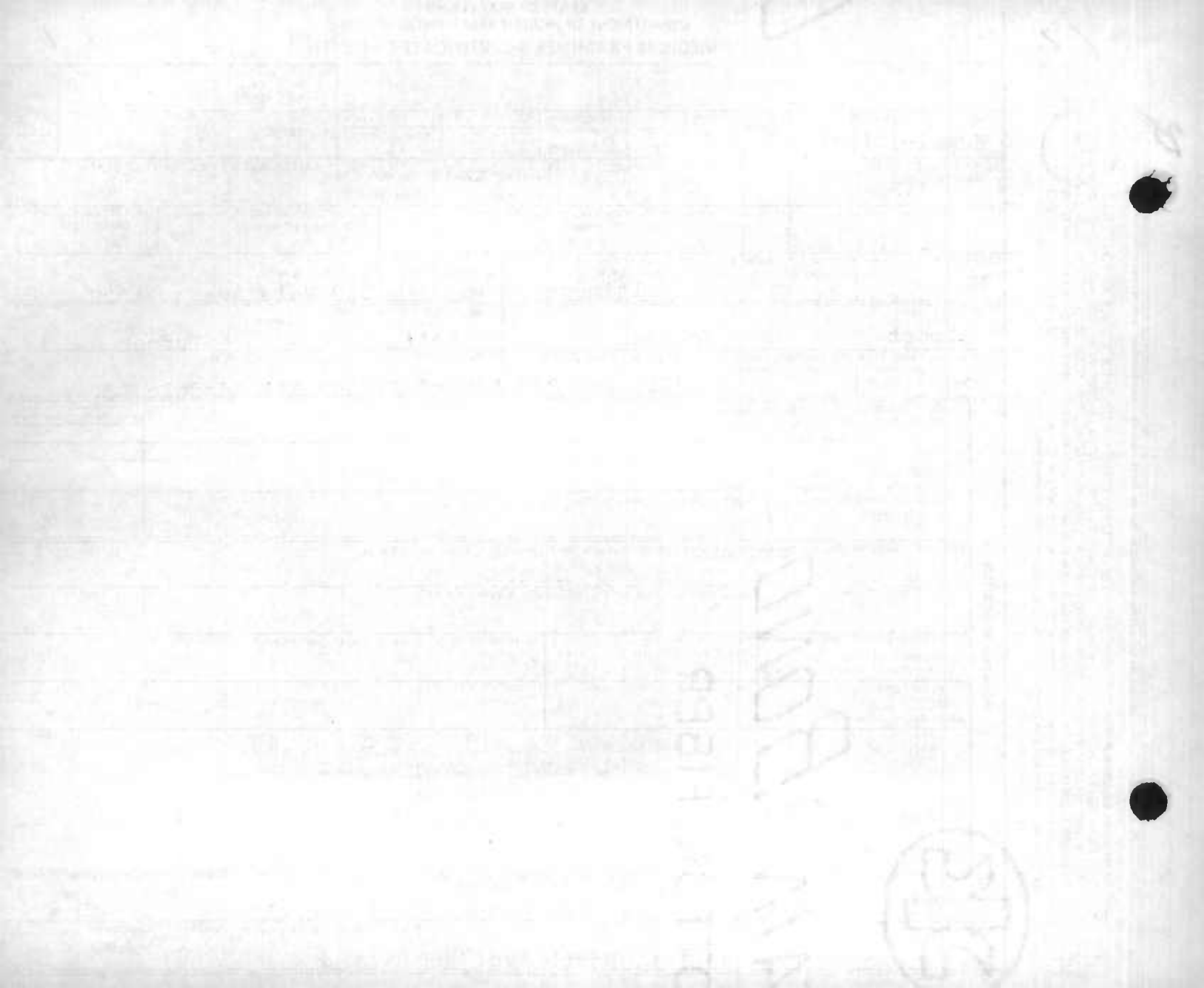
TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be  
replied by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2  
should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death  
with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 8 7 8

REG. NO.

|   |   |   |  |                            |  |
|---|---|---|--|----------------------------|--|
| 1. FOR STATE REGISTRAR  |   | 2a. DATE OF DEATH   |  | 2b. HOUR                   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |   | MONTH DAY YEAR  |  | 11 07 AM                   |  |
| Bernard c. Handy  |   | 11-5-84   |  |                            |  |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)                                | IF UNDER 1 YEAR            |  |
| male  | black   | MONTH DAY YEAR  | 57   | MONTHS DAYS HOURS MIN.     |  |
|   |   | 5 27 27   |  |                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |                            |  |
| Baltimore, MD   | USA   |   | Baltimore City MD  |                            |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)   | 12b. KIND OF BUSINESS OR INDUSTRY                              |                            |  |
| Baltimore   | Mercy Hospital  | brick layer   | construction   |                            |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  | 13b. CITY OR TOWN   | 13c. STREET ADDRESS   | 21216  |                            |  |
| Maryland  | Baltimore City  | 3616 Gwynns Falls Pkwy  |  |                            |  |
| 14. FATHER'S NAME   | 15. MOTHER'S MAIDEN NAME  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |                            |  |
| Willie Cheeks   | Geneva Handy  | YES   |  |                            |  |
| 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS   |  |                            |  |
| 220-14-2360   |   | Geneva Williams 3016 Gwynn Falls Pkwy   |  |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:   |   |   |  |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Cardiopulmonary Arrest  |   |   |  |                            |  |
| DUE TO, OR AS A CONSEQUENCE OF  |   |   |  |                            |  |
| (b) Anterior MI   |   |   |  |                            |  |
| DUE TO, OR AS A CONSEQUENCE OF  |   |   |  |                            |  |
| (c) Cardiomyopathy  |   |   |  |                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |   |   |  |                            |  |
| Chronic Renal Failure, Hypertension   |   |   |  |                            |  |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  | 20a. AUTOPSY?   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                            |  |
| 11/1/84   | AV graft for dialysis   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |                            |  |
|   | P.M. 19   |   |  |                            |  |
| 21d. INJURY OCCURRED  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    | 21f. LOCATION   |  |                            |  |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |   | STREET CITY OR TOWN COUNTY STATE  |  |                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/9/84, 19 84, to Nov 5, 19 84, that (I) (we) last saw the deceased alive on Nov 5, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |  |                            |  |
| 22b. SIGNATURE  |   | DEGREE  | 22c. DATE SIGNED   |                            |  |
| Kathleen M. Fanning MD  |   | MD  | 11/6/84  |                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |   | 22e. ADDRESS  |  |                            |  |
| Kathleen M. Fanning, MD   |   | 301 St. Paul Place, Baltimore   |  |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  | 23b. DATE   | 23c. NAME OF CEMETERY OR CREMATORY  | 23d. LOCATION  |                            |  |
| Burial  | 11/9/74   | Garrison Forest VA  | Owings Mills MD  |                            |  |
| 24. FUNERAL DIRECTOR  |   | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE |  |
| NAME ADDRESS  |   | NOV 7 1984  |  | K. Davidson-Randall        |  |
| William C. March F/H 1101 E. North Ave  |   |   |  |                            |  |

BP

2



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 8 7 9

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |   |
|--|--|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Guy M. Harding</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 21 1984</b>                                    |   | 2b. HOUR<br>M   |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 19 1894</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>90</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Indiana</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2515 Hamilton Avenue</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. Pennsylvania R.R.</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY                                 |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b> |  | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>2515 Hamilton Ave. 21214</b> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Daniel W. Harding</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Roxanna</b>   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>717-03-3412</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Eugene R. Kane 2515 Hamilton Ave. 21214</b>                      |   |

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**Cardiorespiratory arrest**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b) **Cerebrovascular accident**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

**Emphysema**

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Carla Wolf Rosenthal MD</b>  |  |  |  | 22c. DATE SIGNED<br><b>11/23/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CARLA WOLF ROSENTHAL, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>3400 Brehm's Lane Baltimore, Maryland</b>                         |  |

|   |                                 |  |  |
|---|---------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                           | 23b. DATE<br><b>Nov 24 1984</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Belair Memorial</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Belair Maryland</b> |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J. Ruck Inc. Baltimore, Maryland</b> |                                 | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 26 1984</b>          |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

12

| NAME          | ADDRESS      | CITY    | STATE | ZIP   |
|---------------|--------------|---------|-------|-------|
| John Doe      | 123 Main St  | Anytown | CA    | 90210 |
| Jane Smith    | 456 Elm St   | Anytown | CA    | 90210 |
| Bob Johnson   | 789 Oak St   | Anytown | CA    | 90210 |
| Alice Brown   | 101 Pine St  | Anytown | CA    | 90210 |
| Charlie White | 202 Pine St  | Anytown | CA    | 90210 |
| Diana Green   | 303 Pine St  | Anytown | CA    | 90210 |
| Frank Black   | 404 Pine St  | Anytown | CA    | 90210 |
| Grace Hall    | 505 Pine St  | Anytown | CA    | 90210 |
| Henry King    | 606 Pine St  | Anytown | CA    | 90210 |
| Ivy Lee       | 707 Pine St  | Anytown | CA    | 90210 |
| Jack Miller   | 808 Pine St  | Anytown | CA    | 90210 |
| Karen Wilson  | 909 Pine St  | Anytown | CA    | 90210 |
| Leo Taylor    | 1010 Pine St | Anytown | CA    | 90210 |
| Mary Evans    | 1111 Pine St | Anytown | CA    | 90210 |
| Nathan Scott  | 1212 Pine St | Anytown | CA    | 90210 |
| Olivia Adams  | 1313 Pine St | Anytown | CA    | 90210 |
| Peter Baker   | 1414 Pine St | Anytown | CA    | 90210 |
| Quinn Clark   | 1515 Pine St | Anytown | CA    | 90210 |
| Rachel Lewis  | 1616 Pine St | Anytown | CA    | 90210 |
| Samuel Hall   | 1717 Pine St | Anytown | CA    | 90210 |
| Tina Young    | 1818 Pine St | Anytown | CA    | 90210 |
| Victor King   | 1919 Pine St | Anytown | CA    | 90210 |
| Wendy Green   | 2020 Pine St | Anytown | CA    | 90210 |
| Xavier White  | 2121 Pine St | Anytown | CA    | 90210 |
| Yvonne Black  | 2222 Pine St | Anytown | CA    | 90210 |
| Zoe Hall      | 2323 Pine St | Anytown | CA    | 90210 |

Page 1 of 1

NOV 88

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |  |  |  |  |  | 8 4 2 9 8 8 0  |  |                                  |  |
|---|--|---|--|---|--|--|--|--|--|--|--|----------------------------------|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   |  |  |  |  |  | REG. NO.   |  |                                  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  | FIRST MIDDLE LAST<br>Baby Girl / <del>Hardy</del> Hardy   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>8 30 84  |  |  |  | 2b. HOUR<br>6 <sup>55</sup> A.M. |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 30 84   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>0 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>0 1  |  | IF UNDER 24 HRS.<br>HOURS MIN.<br>42                   |  |                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City. MD.  |  |  |  |  |  |                                  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Sinai Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Newborn  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>None  |  |  |  |                                  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>Sinai Hospital 21215  |  |  |  |  |  |                                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Isaiah Hardy  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Smith   |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No                     |  |  |  | 16b. SOCIAL SECURITY NO.<br>None |  |
| 17. INFORMANT<br>Mary Smith   |  |   |  | ADDRESS<br>2 Charleswood Ct 21207   |  |  |  |  |  |  |  |                                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ERECT prematurity hyperventilation</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>prematurity</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>immature lungs</u> |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 hrs. |  |                                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>chorioamnionitis</u>   |  |   |  |   |  |  |  |  |  |  |  |                                  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |                                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)  |  |  |  |  |  |  |  |                                  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |                                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>30 August</u> , 19 <u>84</u> , to <u>30 August</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>30 August</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                       |  |   |  |   |  |  |  |  |  |  |  |                                  |  |
| 22b. SIGNATURE<br>Saeel Keller MD   |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>30 August 1984   |  |  |  |                                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>David M Keller   |  |   |  |   |  | 22e. ADDRESS<br>Sinai Hospital, Baltimore MD   |  |  |  |  |  |                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>cremation   |  | 23b. DATE<br>9-18-84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Sinai Hospital  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore City, Baltimore MD   |  |  |  |  |  |                                  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Sinai Hospital  |  |   |  |   |  | 25. DATE RECEIVED BY REGISTRAR<br>NOV 14 1984<br>Julia Davidson-Rendall  |  |  |  |  |  |                                  |  |

MEDICAL CERTIFICATION

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200.

STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

8 4 2 9 8 8 1

REG. NO.

|  |  |  |  |   |  |   |  |  |  |   |  |
|--|--|--|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Howard Jerome HARDY   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 11, 1984               |   |  | 2b. HOUR<br>3:15AM  |  |  |  |   |  |
| 3. SEX<br>male   |  | 4. RACE<br>white   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Aug. 24, 1907   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |  | 8. IF UNDER 24 HRS.<br>HOURS MIN.                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                     |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Federal Hill Nursing Home |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Stock man/Ret A&P Warehse |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                          |   |  |
| 13a. STATE<br>MD   |  |  | 13b. COUNTY<br>XX  |   | 13c. CITY OR TOWN<br>Baltimore   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>4807 Westland Blvd 21227 |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Millard Hardy  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>(UNKNOWN)   |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>unknown  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br>XXXXXXXXXX |   | 17. INFORMANT<br>ADDRESS<br>Glen Burnie, MD  |   |  | Sharon Woods (daughter in law)   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>respiratory arrest</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>chronic obstructive pulmonary disease</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>myocardial infarction</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>myocardial</i> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><i>prostatic adenocarcinoma stage A2</i>  |  |  |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)   |   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11/11</i> 19 <i>84</i> to <i>present</i> 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>11/11</i> 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><i>Ray Brodie Jr MD</i>  |  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  | 22c. DATE SIGNED<br><i>11/12/84</i>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Ray Brodie MD   |  |  |  |   | 22e. ADDRESS<br>844 N. Carey Street  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation  |  |  | 23b. DATE<br>12 Nov. 1984  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Security Process   |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Catonsville AA MD  |  |   |  |
| 24. FUNERAL DIRECTOR<br><i>Singleton Funeral Home</i>  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 13 1984   |   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Glen Burnie, MD</i>   |  |   |  |

 TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the instructions on the reverse, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

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Charles Robert Thompson

Private Secretary

Oct 1st 1861

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DHMH - 17  
(VR A15 ME (5))  
20M 4/82

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR TO FUNERAL DIRECTOR; PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                     |   |   |   |   |   |   |   |  | REG. NO. 29882 |  |
|--|---------------------|---|---|---|---|---|---|---|--|----------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ALICE Genevieve HARMAN</b>  |                     |   |   |   |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH <b>11</b> DAY <b>22</b> YEAR <b>84</b> |   | 2b. HOUR <b>M</b>   |  |                |  |
| 3. SEX<br><b>F</b>   | 4. RACE<br><b>W</b> | 5. DATE OF BIRTH<br>MONTH <b>12</b> DAY <b>28</b> YEAR <b>10</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS.                 | IF UNDER 1 YR.<br>MONTHS <b></b> DAYS <b></b>   | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b>                                | 2c. DATE PRONOUNCED DEAD<br><b>11 28 84</b>   |   | 2d. HOUR <b>12:26P</b>  |  |                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |                     | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |   |   |  |                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                     | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3614 Delverne Road</b> |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>                                     |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>                                |  |                |  |
| 13a. STATE<br><b>MD</b>  |                     | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                       |   | 13e. STREET ADDRESS<br><b>3614 Delverne Rd., 21218</b>                              |  |                |  |
| 14. FATHER'S NAME<br>FIRST <b>Thomas</b> MIDDLE <b>J.</b> LAST <b>Eubank</b>   |                     |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Alice</b> MIDDLE <b></b> LAST <b>Robertson</b>   |   |   |   |   |  |                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |                     |   |   | 16b. SOCIAL SECURITY NO.<br><b>215 01 3549</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Leonard C. Harman, Jr., TN</b>   |   |   |  |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>  |                     |   |   |   |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |                     |   |   |   |   |   |   |   |  |                |  |
| 19a. DATE OF OPERATION   |                     |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                 |   |   |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                     |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b> |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |   |   |  |                |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                     |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)       |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |   |   |  |                |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                     |   |   |   |   |   |   |   |  |                |  |
| ACTUAL SIGNATURE <b>Margarita A. Korell</b>  |                     |   | TITLE (SPECIFY)<br><b>Assistant</b>                               |   |   | DATE SIGNED <b>11/29/84</b>   |   |   |  |                |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Margarita A. Korell, M.D.</b>  |                     |   | ADDRESS<br><b>111 Penn Street, Baltimore, MD 21201</b>            |   |   |   |   |   |  |                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |                     | 23b. DATE<br><b>12/1/84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley</b>   |   |   | 23d. LOCATION<br>CITY OR TOWN <b>Balto.</b> COUNTY <b>County,</b> STATE <b>MD</b> |   |  |                |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Henry W. Jenkins &amp; Sons Co.</b>  |                     |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 30 1984</b>                           |   | 25b. REGISTRAR'S SIGNATURE<br><b>Lelia Davidson</b>                               |   |  |                |  |
| ADDRESS<br><b>4905 York Road Balto., MD 21212</b>  |                     |   |   |   |   |   |   |   |  |                |  |





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J. E. Brown  
1914  
California  
J. E. Brown

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/82  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |   |  |  |  |                        | 8 4 2 9 8 8 3  |  |  |  |
|---|--|--|--|---|---|--|--|--|------------------------|--|--|--|--|
| 1- FOR STATE REGISTRAR  |  |  |  |   |   |  |  |  |                        | REG. NO.   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MAMIE Elizabeth HARPER</b>  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 17 84</b>  |  |  |  | 2b. HOUR<br><b>1</b> M |  |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 29 08</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |                        |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore, Md</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b> MD.                         |  |  |                        |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MERCY HOSPITAL</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |                        |  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |                        | 13e. STREET ADDRESS<br><b>1218 Argyle Ave 21217</b>        |  |  |  |
| 13a. STATE<br><b>Md</b>   |  | 13b. COUNTY<br><b>Balt city</b>  |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |   |  |  |  |                        |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James Hamilton</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth</b>                               |  |  |  |                        |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>UNKNOWN</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>218-36-4820</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Rosalie Brown &amp; Dorothy Lewis<br/>1218 Argyle Ave.</b>   |   |  |  |  |                        |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>HYPOTENSION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>↓ HCT, platelets, aplastic anemia</b> |  |  |  |   |   |  |  |  |                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH               |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><b>Aplastic Anemia, lung pneumonia</b>  |  |  |  |   |   |  |  |  |                        |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                        |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |  |                        |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21i. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |                        |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 17</b> , 19 <b>84</b> , to <b>Nov 17</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>Nov 17</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                              |  |  |  |   |   |  |  |  |                        |  |  |  |  |
| 22b. SIGNATURE<br><b>William Waschlar</b> M.D.  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   |  |  | 22c. DATE SIGNED<br><b>11/17/84</b>  |                        |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>WILLIAM WASCHLAR</b>  |  |  |  | 22e. ADDRESS<br><b>2239 Roxane Dr Balt Md</b>   |   |  |  |  |                        |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>burial</b>  |  | 23b. DATE<br><b>11/21/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Memorial Park</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md</b>                       |  |  |                        |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>LEROY O. DYETT</b>   |  |  |  |   |   |  |  |  |                        | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 19 1984</b>        |  |  |  |
| 4600 Liberty Hgts. Ave.   |  |  |  |   |   |  |  |  |                        | 25b. REGISTRAR'S SIGNATURE<br><b>Jula Davidson-Randall</b> |  |  |  |

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U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 29884

|   |                         |  |  |   |   |   |  |   |  |
|---|-------------------------|--|--|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Bertha Harris</b>   |                         |  |  | 2a. DATE KNOWN OF DEATH<br><input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR<br><b>11/9/84</b>           |   |   |  | 2b. HOUR<br><b>AM</b>   |  |
| 3. SEX<br><b>FEMALE</b>   | 4. RACE<br><b>BLACK</b> | 5. DATE OF BIRTH<br>MONTH <b>7-</b> DAY <b>12-</b> YEAR <b>21</b>  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br><b>63</b> YRS. | IF UNDER 1 YR.<br>MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>   | IF UNDER 24 HRS.<br>HOURS <input type="checkbox"/> MIN <input type="checkbox"/> | 7c. DATE PRONOUNCED DEAD<br><b>11/9/84</b>  |  | 7d. HOUR<br><b>9:21</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b> MD                               |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1920 Penrose Ave.</b> |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>               |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>MARYLAND</b>   |                         | 13b. COUNTY<br><b>U.S.A</b>  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1920 PENROSE AVENUE</b>                                   |  |
| 14. FATHER'S NAME<br>FIRST <b>JOHN L.</b> MIDDLE <b>LIPSCOME</b> LAST   |                         |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>MARY</b> MIDDLE <b>V.</b> LAST <b>BANNISTER</b>  |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>NO</b>  |                         | 16b. SOCIAL SECURITY NO.<br><b>-</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>LUCILLE WARRELL 3703 DOLFIELD AVENUE</b>   |   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |                         |  |  |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |                         |  |  |   |   |   |  |   |  |
| 19a. DATE OF OPERATION  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |   |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                         | 21e. PLACE OF INJURY (AT HOME, STREET, PARK, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |   |  |
| 22. I certify that I took charge of the remains described above, held on<br>death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion |                         |  |  |   |   |   |  |   |  |
| ACTUAL SIGNATURE<br><i>Thomas D. Smith</i>  |                         | TITLE (SPECIFY)<br>M.D. <b>Dep. Chief</b> MEDICAL EXAMINER   |  |   |   |   |  | DATE SIGNED<br><b>11/9/84</b>   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Thomas D. Smith, M.D.</b>  |                         | ADDRESS<br><b>111 Penn St.</b>   |  |   |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |                         | 23b. DATE<br><b>11-14-84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CEDAR HILL</b>   |   | 23d. LOCATION<br>CITY OR TOWN <b>GLEN BURNIE, MARYLAND</b> COUNTY STATE                         |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>E.L. PHILLIPS</b> ADDRESS<br><b>1721-27 N. MONROE ST. 21217</b>  |                         |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 15 1984</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><i>John Davidson</i>  |  |   |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 8 8 5

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OF PRINT) FIRST MIDDLE LAST<br><b>CHARLES LEE HARRIS</b>  |  |   | 7a. DATE OF DEATH MONTH DAY YEAR<br><b>NOVEMBER 22, 1984</b>                   |  | 7b. HOUR<br><b>1:34</b> P M  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>Black</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 13 34</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>50</b> YRS                               |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MD</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD               |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><b>MD</b>  |  |   | 13b. COUNTY  | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Grover Harris</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Roberta Thornton</b>       |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>213-30-5381</b>  | 17. INFORMANT ADDRESS<br><b>Helen B. Harris 4611 old Frederick Rd.</b>         |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Sepsis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Chronic renal failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Hypertension</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>3 months</u><br><u>2 years</u><br><u>20 years</u> |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><u>Baotic stenosis with valve replacement</u>   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |
| 21d. INJURY OCCURRED<br>AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July 30</u> 19 <u>84</u> , to <u>Nov 22</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>Nov 22</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                     |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Daniel E Ford, M.D.</u>  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><u>11/22/84</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DANIEL E FORD</b>   |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital Baltimore MD</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>11/27/84</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Forest VA</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Owings Mills MD</b>                 |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H 1101 E. North Ave.</b>  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 26 1984</b>                            |  | 25b. REGISTRAR'S SIGNATURE<br><u>John Davidson-Randall</u>   |

MEDICAL CERTIFICATION

29

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours of death. It is the responsibility of the attending physician to complete this certificate and to have it signed by the attending physician and completely filled out by the attending physician. After this certificate has been signed by the attending physician and completely filled out by the attending physician, it should be detached for use on the burial-transit permit. Then please indicate on the burial-transit permit, Part 2, should be filled with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MICU

0-123-26  
HARRIS, CHARLES LEE  
07/13/34

80% COTTON 1985B

CHIEF M. W. B. H. H.



MADE IN U.S.A.

100% COTTON

WICH



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 8 8 6

FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |  |   |   |  |  |  |
|---|--|--|--|---|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Gloria (Gloris) A. Harris  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 26 84                        |   |  | 2b. HOUR<br>9 A.M.  |   |  |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Black   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 19 28   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>56 YRS.                                |   |  |  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>J. L. DEATON Medical Center |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)          |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD  |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br>Baltimore   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>1233 N. Broadway 21213 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Samuel Roberts  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Alice Murphy   |  |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  |  | 16b. SOCIAL SECURITY NO.<br>219-22-1135                                |   | 17. INFORMANT<br>ADDRESS<br>Samuel Roberts 1233 N. Broadway                    |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>aspiration pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>seizure</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 min<br>1 day<br>1 day  |  |  |
|   |  |  |  |   |  |   |   |  |  |  |
|   |  |  |  |   |  |   |   |  |  |  |
|   |  |  |  |   |  |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Bilateral frontal Cerebral Hemorrhage w/ coma.</u>  |  |  |  |   |  |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 6</u> , 19 <u>84</u> , to <u>Nov 26</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>Nov 26</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.             |  |  |  |   |  |   |   |  |  |  |
| 22b. SIGNATURE<br><u>Kevin Ferrenti MD</u>  |  |  |  |   | DEGREE   |   |   | 22c. DATE SIGNED<br><u>11/26/84</u>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>KEVIN FERRENTI MD</u>   |  |  |  |   | 22e. ADDRESS<br><u>611 S. Charles St. (Deaton)</u>                             |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |  | 23b. DATE<br>11/30/84  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cem.                          |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Anne Arundel Co MD                                |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H 1101 E. North Ave.   |  |  |  |   | 25. DATE REC'D. BY REGISTRAR<br>NOV 28 1984                                    |   |   |  |  |  |
|   |  |  |  |   | 25. REGISTRAR'S SIGNATURE<br><u>John Davidson</u>                              |   |   |  |  |  |

BP



**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. **29887**

**1- FOR  
STATE  
REGISTRAR**

|   |                                |   |  |   |   |   |  |
|---|--------------------------------|---|--|---|---|---|--|
| <b>1. DECEASED NAME</b><br>(TYPE OR PRINT) <b>James J. Harris</b>   |                                |   |  | <b>2a. DATE KNOWN OF DEATH</b> <input checked="" type="checkbox"/> <b>11/17/84</b>  |   | <b>2b. HOUR</b><br>P <b>2:03</b>  |  |
| <b>3. SEX</b><br><b>Male</b>  | <b>4. RACE</b><br><b>White</b> | <b>5. DATE OF BIRTH</b><br>MONTH <b>Sept</b> DAY <b>26</b> YEAR <b>1920</b>   | <b>6. AGE (IN YEARS LAST BIRTHDAY)</b><br><b>64</b> YRS. | <b>IF UNDER 1 YR.</b><br>MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.  | <b>2c. DATE PRONOUNCED DEAD</b><br><b>11/17/84</b>                                    |   | <b>2d. HOUR</b><br>P <b>2:03</b>   |
| <b>7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)</b><br><b>Maryland</b>   |                                | <b>7b. CITIZEN OF WHAT COUNTRY?</b><br><b>U.S.A.</b>  |  | <b>8. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input checked="" type="checkbox"/> |   | <b>9. BALTIMORE CITY OR COUNTY OF DEATH</b><br><b>Baltimore City,</b> MD                          |  |
| <b>10. CITY OR TOWN OF DEATH</b><br><b>Baltimore</b>  |                                | <b>11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION</b><br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Union Memorial Hospital</b> |  |   | <b>12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)</b><br><b>Lather</b> |   | <b>12b. KIND OF BUSINESS OR INDUSTRY</b><br><b>Construction</b>  |
| <b>13a. STATE</b><br><b>Maryland</b>  |                                |   |  | <b>13b. COUNTY</b><br><b>Baltimore</b>  | <b>13c. CITY OR TOWN</b><br><b>Baltimore</b>  |   |  |
| <b>13d. INSIDE CITY LIMITS?</b><br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                |   |  | <b>13e. STREET ADDRESS</b><br><b>3506 Elm Avenue 21211</b>  |   |   |  |
| <b>14. FATHER'S NAME</b><br>FIRST <b>Clarence</b> MIDDLE <b>HaRRIS</b> LAST   |                                |   |  | <b>15. MOTHER'S MAIDEN NAME</b><br>FIRST <b>Nellie</b> MIDDLE <b>Porter</b> LAST <b>Marsh</b>   |   |   |  |
| <b>16a. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(YES, NO, OR UNKNOWN)<br><b>Yes</b>  |                                | <b>16b. SOCIAL SECURITY NO.</b><br>(IF YES, GIVE WAR OR DATES)<br><b>WW II</b>  |  | <b>17. INFORMANT</b><br>ADDRESS<br><b>Daniel C. Harris 3506 Elm Ave. 21211</b>  |   |   |  |
| <b>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</b>  |                                |   |  |   |   |   | <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>  |
| <b>PART I DEATH WAS CAUSED BY:</b>  |                                |   |  |   |   |   |  |
| <b>IMMEDIATE CAUSE (a)</b> <u>Arteriosclerotic Cardiovascular Disease</u>   |                                |   |  |   |   |   |  |
| <b>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a) STATING THE UNDERLYING CAUSE LAST:</b>  |                                |   |  |   |   |   |  |
| <b>(b)</b> _____  |                                |   |  |   |   |   |  |
| <b>DUETO, OR AS A CONSEQUENCE OF</b>  |                                |   |  |   |   |   |  |
| <b>(c)</b> _____  |                                |   |  |   |   |   |  |
| <b>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1</b>   |                                |   |  |   |   |   |  |
| <b>19a. DATE OF OPERATION</b>   |                                |   |  | <b>19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?</b>  |   |   | <b>20. AUTOPSY?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |
| <b>21a. EXTERNAL CAUSE WAS</b><br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                                | <b>21b. TIME OF INJURY</b><br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | <b>21c. HOW INJURY OCCURRED</b> (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |   |   |  |
| <b>21d. INJURY OCCURRED</b><br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                                | <b>21e. PLACE OF INJURY</b> (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | <b>21f. LOCATION</b><br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |
| <b>22a. I certify that I took charge of the remains described above, held on</b>  |                                |   |  |   |   |   | <b>Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and in my opinion</b> |
| <b>death resulted from:</b> <b>Natural causes</b> <input checked="" type="checkbox"/> <b>Accident</b> <input type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined manner</b> <input type="checkbox"/> . |                                |   |  |   |   |   |  |
| <b>ACTUAL SIGNATURE</b> <i>Margarita A. Korell</i>  |                                |   |  | <b>TITLE (SPECIFY)</b><br>M.D. <b>Assistant</b> MEDICAL EXAMINER  |   | <b>DATE SIGNED</b> <b>11/18/84</b>  |  |
| <b>EXAMINER'S NAME (TYPE OR PRINT)</b><br><b>Margarita A. Korell, M.D.</b>  |                                |   |  | <b>ADDRESS</b><br><b>111 Penn St.</b>   |   |   |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (SPECIFY)</b><br><b>Cremation</b>  |                                | <b>23b. DATE</b><br><b>11-14-84</b>   |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><b>Westview Crematory</b>  |   | <b>23d. LOCATION</b><br>CITY OR TOWN <b>Catonsville,</b> COUNTY <b>Balto Co.</b> STATE <b>Md.</b> |  |
| <b>24. FUNERAL DIRECTOR</b><br>NAME <b>Burgee - Henss Funeral Home, Balto., Md.</b> ADDRESS   |                                |   |  | <b>25a. DATE REC'D. BY REGISTRAR</b><br><b>NOV 23 1984</b>  |   | <b>25b. REGISTRAR'S SIGNATURE</b><br><i>Julia Davidson-Randall</i>                                |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201



100% COTTON LEEB

MADE IN USA

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 8 8 8

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |  |  |   |  |   |  |   |  |
|---|--|--|--|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Leroy</b>   |  |  | FIRST MIDDLE LAST<br><b>Harris</b>   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11-13-84</b>   |  |   | 2b. HOUR<br><b>7:15 PM</b>   |   |  |
| 3. SEX<br><b>MALE</b>   |  |  | 4. RACE<br><b>BLACK</b>  |  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>AUG. 11, 1904</b>   |  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US of A</b>   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSPITAL</b> |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>  |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>LIBRARIAN</b>  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>  |  |  |  |  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>CATONSVILLE</b> |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>WILLIAM HARRIS</b>   |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>SARAH DARE</b>  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>215 16 7941A</b>   |  |  | 17. INFORMANT ADDRESS<br><b>MRS. CARRIE S. HARRIS 6 DUNBAR AVE. 21228</b>   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cordicerepat ariet</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |  |  |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/7</b> 19 <b>84</b> to <b>11/13</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>11/13</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the day and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>ACEVEDO</b>  |  |  |  |  |  | DEGREE<br><b>MD</b>   |  |   | 22c. DATE SIGNED<br><b>11/13/84</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ACEVEDO</b>   |  |  |  |  |  | 22e. ADDRESS<br><b>St Agnes Hospital</b>  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  |  | 23b. DATE<br><b>11/20/84</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MARYLAND NAT. MEM. PK.</b>   |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>LAUREL (PRINCE GEO.) MD.</b>  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>LEWIS T. GWYNN</b>   |  |  |  |  |  | ADDRESS<br><b>4517 PARK HEIGHTS AVENUE</b>  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 15 1984</b>  |   |  |
|   |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>  |  |   |  |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11/30/34

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

29889  
REG. NO.

1. FOR UNK.#84-88  
STATE REGISTRAR

|  |                              |                  |  |                |                  |  |  |  |
|--|------------------------------|------------------|--|----------------|------------------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                |                              |                  | 2a. DATE KNOWN OF ESTI. DEATH MATED  |                |                  | 2b. HOUR   |  |  |
| Jefferson Harrison   |                              |                  | 11-16 19 84  |                |                  | 4:55 a.m.  |  |  |
| 3. SEX   | 4. RACE                      | 5. DATE OF BIRTH | 6. AGE (IN YEARS)  | IF UNDER 1 YR. | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD                                     |  |  |
| MALE   | BLK.                         | 3 4 14 70        | 70 YRS.  |                |                  | 11-16 19 84  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                          | 7b. CITIZEN OF WHAT COUNTRY? |                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                |                  | 9. BALTIMORE CITY OR COUNTY OF DEATH                         |  |  |
| S. CAROLINA  | USA.                         |                  |  |                |                  | Baltimore City, MD   |  |  |
| 10. CITY OR TOWN OF DEATH  |                              |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION   |                |                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF LIVING LIFE) |  |  |
| Baltimore  |                              |                  | War Memorial Plaza   |                |                  | LONG SHORE MAN 21229   |  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY                                  |                              |                  |  |                |                  |  |  |  |
|  |                              |                  |  |                |                  |  |  |  |
| 13a. STATE   |                              |                  |  |                |                  |  |  |  |
| Md.  |                              |                  |  |                |                  |  |  |  |
| 13b. COUNTY  |                              |                  |  |                |                  |  |  |  |
| BALTO.   |                              |                  |  |                |                  |  |  |  |
| 13c. STREET ADDRESS  |                              |                  |  |                |                  |  |  |  |
| 5052 WEST HILLS RD.  |                              |                  |  |                |                  |  |  |  |
| 14. FATHER'S NAME  |                              |                  | 15. MOTHER'S MAIDEN NAME   |                |                  |  |  |  |
| WADUS  |                              |                  | ROSE HARRISON  |                |                  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) |                              |                  | 16b. SOCIAL SECURITY NO.   |                |                  | 17. INFORMANT ADDRESS  |  |  |
|  |                              |                  | 850-10-5936  |                |                  | Dorothy Gorham NESAMs Rd.                                    |  |  |

|  |  |  |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY: |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Diabetes mellitus &amp; arteriosclerotic Cardiovascular disease</u>               |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |
| (b) _____  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |
| (c) _____  |  |  |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

|   |  |   |   |   |
|---|--|---|---|---|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |   | 20. AUTOPSY?  |
|   |  |   |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |
|   |  | P.M. 19   |   |   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>              |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |   |
|   |  |   |   |   |

|  |  |                                 |  |             |
|--|--|---------------------------------|--|-------------|
| 22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from |  | TITLE (SPECIFY)                 |  | DATE SIGNED |
| Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                             |  | Deputy Chief                    |  | 11-16-84    |
| ACTUAL SIGNATURE   |  | MEDICAL EXAMINER                |  |             |
| EXAMINER'S NAME (TYPE OR PRINT)  |  | ADDRESS                         |  |             |
| Thomas D. Smith, M.D.  |  | 111 Penn St., Balto., Md. 21201 |  |             |

|   |           |                                    |   |
|---|-----------|------------------------------------|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE |
|   | 11-22-84  | Louden Park                        | BALTO. MD.                              |
| 24. FUNERAL DIRECTOR NAME                 |           | 25. REGISTRAR'S SIGNATURE          |   |
| Sharon Carrole                            |           | NOV 23 1984                        |   |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IN EXECUTING THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 4. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 8 9 0

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |   |   |  |  |   |
|--|---|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Lizzie - Harrison</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>Nov. 27 1984</b> 24 <sup>58</sup> M |  |   |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>Black</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>8 28 93</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>91</b>                               |  | 7b. HOUR  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>N. C.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.             |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Keswick N. H.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)           |  | 12b. KIND OF BUSINESS OR INDUSTRY                           |
| 13a. STATE<br><b>Md.</b>   |   |   | 13b. COUNTY<br><b>Balto.</b>   | 13c. CITY OR TOWN<br><b>Balto.</b>   |   |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |   | 13e. STREET ADDRESS / ZIP CODE<br><b>1613 E. 30th St. 21218</b>            |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>UNK</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Winnie Harris</b>      |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>NO</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Jessie Simpson 1613 E. 30th St.</b>             |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ASCVD</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Yrs.</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><b>Traumatic Quadriplegia 2 yrs 3 months</b>   |   |   |  |  |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |   |  |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>14 Mar 83</b> to <b>27 Nov 84</b> that (I) (we) lost<br>saw the deceased alive on <b>27 Nov 84</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>about (I) (we) (did) (did not) view the body after death.    |   |   |  |  |   |
| 22b. SIGNATURE<br><b>Aubrey D. Richardson M.D.</b>   |   | DEGREE  |  | 22c. DATE SIGNED<br><b>27 Nov 1984</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Aubrey D. Richardson MD</b>  |   | 22e. ADDRESS<br><b>Keswick - 700 W. 40th St. 21211</b>  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>12/1/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Balto. Cem.</b>                       |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>  |   |   |  |  |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Ave.</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 29 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Liza Davidson-Randall</b>                     |   |

70  
90  
35  
300  
1

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted at once.

1



BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE FUNERAL DIRECTOR. PAGE 5 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  | REG. NO. 29891                          |  |
|--|--|--|--|--|--|--|--|--|--|---|--|
| 1- FOR STATE REGISTRAR   |  |  |  |  |  | 2a. DATE KNOWN OF DEATH  |  | MONTH DAY YEAR   |  | 2b. HOUR                                |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Richard O. Harrison</b>  |  |  |  |  |  | DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MATED <input type="checkbox"/>       |  | 11/9/84  |  | M                                       |  |
| 3. SEX <b>male</b>   |  | 4. RACE <b>black</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>9 8 17</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS.   |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.  |  | 7c. DATE PRONOUNCED DEAD <b>11/9/84</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Va.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City,</b> MD.                              |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1923 W. Lanvale St.</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>Md</b>  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN <b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>21217 1923 W. Lanvale Street</b>                          |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Wyatt</b>   |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Della Penn</b>                                 |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>   |  |  |  | 16b. SOCIAL SECURITY NO. <b>246-30-1984</b>  |  | 17. INFORMANT ADDRESS <b>Hattie Goggins 1923 W. Lanvale St.</b>                              |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of Lungs</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |  |  |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |  |  |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE <b>Thomas D. Smith</b>  |  |  |  | TITLE (SPECIFY) <b>Dep. Chief</b>  |  |  |  | DATE SIGNED <b>11/9/84</b>   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>   |  |  |  | ADDRESS <b>111 Penn St.</b>  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>11/14/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Church Cemetery</b>  |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Weldon N.C.</b>                       |  |   |  |
| 24. FUNERAL DIRECTOR NAME <b>William C. March F/H 1101 E. North Ave</b>  |  |  |  |  |  | 25. DATE RECEIVED BY REGISTRAR <b>NOV 13 1984</b>  |  |  |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

#8, 13, 17, FilmG598 12/6/84 kam

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 4 2 9 8 9 2  
REG. NO.

|  |  |   |  |   |  |   |   |   |  |
|--|--|---|--|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>THEODORE ROOSEVELT HARRISON</b>          |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 16 1984</b>               |   |  | 2b. HOUR<br>M<br><b>AM</b>  |   |   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>BLACK</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>FEB. 9, 1925</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><b>59</b>  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>New Jersey</b>                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  | 8. <del>MARRIED</del> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Union Memorial Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Motor Vehicle Oper. Government</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U. S.</b> |  |
| 13a. STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Clarence Harrison</b>                 |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Gertrude Moore</b> |   |  | 16. STREET ADDRESS / ZIP CODE<br><b>2107 Oak Avenue</b>   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b> |  |   | 16b. SOCIAL SECURITY NO.<br><b>WW II</b>                               |   | 17. INFORMANT<br><b>2104 Druid Hill Ave. Monterey B. Harrison Baltimore, Md. 21217</b> |   |   |   |  |

|   |  |   |  |
|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>A. tris secundum</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) <u>year</u> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Months</u> |  |
|---|--|---|--|

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>none</u>  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10-31-84</u> to <u>11-16-84</u> , that (I) (we) last saw the deceased alive on <u>10-31-84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Daniel J. Hill M.D.</u>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><u>11/19/84</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Daniel J. Hill</u>  |  |  |  | 22e. ADDRESS<br><u>10219 S. Redford Rd.</u>  |  |  |  |

|   |  |                                |  |   |  |  |  |
|---|--|--------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11/21/1984</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Forest Veterans</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Owings Mills, Md.</b> |  |
| 24. FUNERAL HOME OR<br>NAME ADDRESS<br><b>Nutter &amp; Sons 2501 Gwynns Falls Parkway<br/>Funeral Home Inc. Baltimore, Maryland 21216</b> |  |                                |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 21 1984</b>                   |  |  |  |

Bureau Home Inc. Baltimore, Maryland 21218  
 Hunter & Jones 1801 Gwynns Falls Parkway  
 11/27/1984 Garrison Forest Veterans Center Hills, Md.

Yes No II 219-18-2125 Monday B. Harrison Baltimore, Md. 21217  
 4907 Park Avenue  
 Moore

Maryland Baltimore 21217  
 Baltimore 21217  
 Union Memorial Hospital  
 Motor Vehicle Over. Government  
 U.S.  
 New Jersey U. S. A.  
 29 1992

THEODORE ROOSEVELT HARRISON 11 16 1984



FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 8 9 3

REG. NO.

|   |  |   |   |  |   |
|---|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>PAULINE L. HARSHMAN</b>                 |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>NOVEMBER 29, 1984</b>                              |  | 2b. HOUR P<br><b>9:45 M</b>   |
| 1. SEX<br><b>Female</b>   | 4. RACE<br><b>Caucasian</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 26 15</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS                   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>                  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                         |  |   |
| 11. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OR WORK FOR MOST OF WORKING LIFE)<br><b>School Teacher</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Education</b>   |
| 13a. STATE<br><b>Pa.</b>  |  |   | 13b. COUNTY<br><b>C Lancaster</b>   | 13c. CITY OR TOWN<br><b>E. Petersburg</b>                          | 13d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Clayton R. Leaman</b>                |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elva S. Kauffman</b>                  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b> |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br><b>N/A</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Mr. Jed C. Harshman Same as #13</b> |   |

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>BRAIN METASTASES</b>  |  | <b>6 mos</b>                                    |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Renal Cell Carcinoma Metastatic</b>   |  | <b>6 mos</b>                                    |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.

**Hypotension, DIABETES**

|   |  |   |   |
|---|--|---|---|
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (this hospital) attended the deceased from <b>11-28-</b> 19 <b>84</b> to <b>11-29-</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>11-29</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |
| 22b. SIGNATURE<br><b>Mark Kozak</b>   | DEGREE<br><b>MD</b>  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED<br><b>11/29/84</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARK KOZAK MD</b>   |  | 22e. ADDRESS<br><b>THE JOHNS HOPKINS HOSPITAL<br/>600 N. WOLFE ST BALTO, MD</b>   |   |

|   |                             |  |   |
|---|-----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  | 23b. DATE<br><b>12-1-84</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cratin &amp; Ferris</b>           | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>West Goshen Chester, Pa.</b> |
| 24. FUNERAL DIRECTOR<br><b>Macabb F.H. Catonsville, Md. 21228</b> |                             | 25. DATE RECD. BY REGISTRAR 26. REGISTRAR'S SIGNATURE<br><b>DEC 3 1984</b> |   |
| 27. Spacht F.H. 127 S. Broad St. Lititz, Pa. 17543                |                             |  |   |



ST JE SIS P  
ST JE SIS P



20% TOLUOL LIGER

WATER

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 84 2989

|  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST MIDDLE LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  | 2b. HOUR P M                                 |  |
|  |  | ALVIN R HARTMANN   |  |  |  | NOVEMBER 18, 1984  |  | 7:45 P M                                     |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.   |  | 7. IF UNDER 1 YEAR MONTHS DAYS               |  |
| Male   |  | White  |  | Jan. 6, 1925   |  | 59   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |
| Ohio   |  | USA  |  |  |  | BALTIMORE CITY MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| BALTIMORE  |  | JOHNS HOPKINS HOSPITAL   |  | Executive  |  | Plastics   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) IN STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE               |  |
| Ohio   |  |  |  | Westlake   |  |  |  | 1350 Glenbrook, 44145                        |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS                        |  |
| John W. Hartmann   |  | Anna Reichwein   |  | Yes WW II  |  | 290 18 0952  |  | Berry's Funeral Home, Ohio                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  |  | IMMEDIATE CAUSE (a)  |  | DUE TO, OR AS A CONSEQUENCE OF (b)   |  | DUE TO, OR AS A CONSEQUENCE OF (c)   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
|  |  | HEPATIC FAILURE  |  | HEPATOCELLULAR ADENOCARCINOMA  |  |  |  | NOV. 13, 1984<br>NOV. 18, 1984               |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a   |  | RENAL FAILURE, ESOPHAGEAL TEAR   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from NOV 18 19 84, to NOVEMBER 18 19 84, that (I) (we) last saw the deceased alive on NOV 18 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (If we did not view the body after death). |  | 22b. SIGNATURE DEGREE  |  | 22c. DATE SIGNED   |  |  |  |  |  |
| R ROUBENOFF, M.D.  |  | M.D.   |  | 11/18/84   |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |  |  |  |  |  |
| R ROUBENOFF, M.D.  |  | JOHNS HOPKINS HOSPITAL   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |  |  |
| Removal-Burial   |  | 11/19/84   |  | Lakewood Park  |  | Rocky River, Ohio  |  |  |  |
| 24. FUNERAL DIRECTOR NAME  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |
| Henry W. Jenkins & Sons Co. 4905 York Road Balto., MD  |  | NOV 20 1984  |  | John Davidson-Randall  |  |  |  |  |  |

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BIRMINGHAM  
ALABAMA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| 1- FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 4 2 9 8 9 5<br>REG. NO.  |  |  |  |
|---|--|--|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Joseph C. Hauf Jr.   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 9, 1984   |  |  |  | 2b. HOUR<br>1:00 PM  |  |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 15 1897  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>87  |  | 7a. IF UNDER 1 YEAR<br>MONTHS DAYS   |  | 7b. IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                     |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF FROM SUCH PLACE, GIVE STREET ADDRESS)<br>4204 Tuscany Ct. 21210 |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Engineer   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. STATE<br>Maryland  |  |  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Balto.  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br>4204 Tuscany Ct. 21210   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joseph C. Hauf Sr.  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Agnes Kelly   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>yes   |  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW 1   |  | 17. INFORMANT<br>ADDRESS<br>21210  |  | Mr. Joseph C. Hauf 111 205 Club Rd.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>HASCD</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 mos<br>10 YRS  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |  |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |  |  |
| 22a. I certify that (I) (the undersigned) attended the deceased from <u>8-21</u> , 19 <u>74</u> , to <u>11-09</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>8-17</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.         |  |  |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>John F. Hartman</u>  |  |  |  | DEGREE<br>M.D.  |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>11-09-84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. John Hartman M.D.  |  |  |  | 22e. ADDRESS<br>422 Med Art Bldg. Balto. Md. 21204  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |  |  | 23b. DATE<br>11/12/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Woodlawn Cemetery                        |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Mitchell-Wiedefeld  |  |  |  |   |  | ADDRESS<br>6500 York Rd.   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 13 1984   |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>Davidson-Randall</u>   |  |  |  |   |  |  |  |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |   |   |  |   |  |  |   | 8  | 4 | 2   | 9   | 8   | 9 | 6   |  |
|---|--|--|---|---|--|---|--|--|---|--|---|---|---|---|---|---|--|
| 1- FOR STATE REGISTRAR  |  |  |   |   |  |   |  |  |   | REG. NO.   |   |   |   |   |   |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>CHARLES E. HAUGHEY, Jr.</b>   |  |  |   |   |  |   |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11-23-84</b>  |   |   |   | 2b. HOUR<br><b>3:45 P.M.</b>  |   |   |  |
| 3. SEX<br><b>MALE</b>   |  |  | 4. RACE<br><b>WHITE</b>   |   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>10-3-08</b>   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS                      |  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |   |   |   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto., Md.</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.S. A.</b>  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>    |  |   |   |   |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Francis Scott Key Med. Cntr.</b> |   |  |   |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Clerk</b>  |   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Steel Co.</b> |   |   |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>   |  |  |   |   |  |   |  |  |   | 13b. COUNTY<br><b>---</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>                           |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br><b>33 S. Potomac Street 21224</b> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Charles E. Haughey, Sr.</b>   |  |  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Elizabeth C. Burgan</b> |   |  |  |   |  |   |   |   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>  |  |  |   |   | 16b. SOCIAL SECURITY NO.<br><b>213-07-3428</b>                           |   | 17. INFORMANT ADDRESS<br><b>Baltimore, Md. 21224.</b><br><b>Mrs. Lola B. Haughey-33 S. Potomac St.</b> |  |   |  |   |   |   |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Parkinsonism</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Emphysema</b><br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>St.</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 wks</b><br><b>years</b><br><b>June 84</b> |  |  |   |   |  |   |  |  |   |  |   |   |   |   |   |   |  |
| 19a. DATE OF OPERATION  |  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |   |   |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |   |   |   |   |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |   |  |   |   |   |   |   |   |  |
| 22a. I certify that (I, this hospital) attended the deceased from <b>8/15</b> , <b>1984</b> , to <b>11/23</b> , <b>1984</b> , that <b>he</b> was <b>alive</b> on <b>11/23</b> , <b>1984</b> , and that in <b>my</b> <b>own</b> opinion death occurred on the date and hour and from the causes stated above. (If I did not view the body after death, so state.)  |  |  |   |   |  |   |  |  |   |  |   |   |   |   |   |   |  |
| 22b. SIGNATURE <b>J. Burton M.</b>  |  |  |   |   |  |   |  | DEGREE   |   | 22c. DATE SIGNED<br><b>11/23/84</b>  |   |   |   |   |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>J. BURTON M.</b>  |  |  |   |   |  |   |  | 22e. ADDRESS<br><b>5200 EASTERN AVE BALTO 21224</b>                            |   |  |   |   |   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |  |   | 23b. DATE<br><b>11/26/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b> |  |   |   |   |   |   |   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>John A. Moran, Inc. Funeral Home</b>  |  |  |   |   |  |   |  | DATE REC'D. BY REGISTRAR<br><b>NOV 27 1984</b>                                 |   | 25b. REGISTRAR'S SIGNATURE<br><b>ma Davidson</b>   |   |   |   |   |   |   |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>3000 E. Baltimore St., Balto., Md. 21224.</b>  |  |  |   |   |  |   |  |  |   |  |   |   |   |   |   |   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |   |  |   |  |  |  |
|---|--|---|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Chester L. Hawkes</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-28-84</b>                      |   |   | 2b. HOUR<br><b>7:55 P.M.</b>   |   |  |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>NEGRO</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JAN 4, 1919</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bon Secours Hosp.</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CUSTODIAL</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  |   | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>3813 BARRINGTON RD. 21215</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>EDDIE S. HAWKES</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>DAISY A. FITZGERALD</b> |   |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |   | 16b. SOCIAL SECURITY NO.<br><b>230-09-6614</b>                              |   | 17. INFORMANT<br>ADDRESS<br><b>ROSA B. HAWKES/3813 BARRINGTON RD. 21215</b> |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest 2°</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Atherosclerotic Heart Disease and</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Congestive Heart Failure.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |   |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Seizure Disorder; Diabetes Mellitus; Hyperkalemia; Chronic Renal Failure; Pneumonia.</b>  |  |   |   |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                            |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                  |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)      |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/4/84</b> to <b>11/28/84</b> , that (I) (we) lost saw the deceased alive on <b>11/28/84</b> , 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.  |  |   |   |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>[Signature]</b>  |  |   | DEGREE<br><b>MD</b>   |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  | 22c. DATE SIGNED<br><b>11/29/84</b>                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HARI K BHASIN MD</b>  |  |   | 22e. ADDRESS<br><b>606 HAMMONDS Lane Balto Md 21225</b>                     |   |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  |   | 23b. DATE<br><b>12/01/84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MD NATL MEM PARK</b>               |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>LAUREL A.A. MARYLAND</b>                       |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>MARSHALL W. JONES, JR.<br/>4101 EDMONDSON AVE./BALTO., Md. 21229</b>   |  |   |   |   |   | 25a. DATE REC'D BY REGISTRAR<br><b>NOV 30 1984</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is marked, the medical examiner will be notified of the death.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST <u>Lester</u> MIDDLE <u>Paul</u> LAST <u>Hawkins</u><br><u>LESTER Paul HAWKINS</u>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><u>November</u> <u>30</u> <u>84</u>           |  | 2b. HOUR<br><u>9:59</u> M  |
| 3 SEX<br><u>MALE</u>  | 4 RACE<br><u>White</u>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><u>Aug</u> <u>3</u> <u>16</u>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>67</u> YRS.                                 |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>West Virginia</u>  | 7b. CITIZEN OF COUNTRY?<br><u>U.S.A.</u>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><u>Baltimore City</u> MD.                  |  |  |
| 10. CITY OR TOWN OF DEATH<br><u>BALTIMORE</u>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>South Baltimore General Hospital</u> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Burner</u> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>Ship Yard</u>  |
| 13a. USUAL RESIDENCE (IF NOT IN HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <u>MARYLAND</u> 13b. CITY OR TOWN <u>BALTIMORE</u>  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 13e. STREET ADDRESS ZIP CODE<br><u>5007 KRAMER AV</u>   |   |  |  |
| 14 FATHER'S NAME<br>FIRST <u>Wesley</u> MIDDLE <u></u> LAST <u>HAWKINS</u>  | 15. MOTHER'S MAIDEN NAME<br>FIRST <u>ADDIE</u> MIDDLE <u>C</u> LAST <u>CHRISLIP</u>  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>No</u>   | 16b. SOCIAL SECURITY NO.<br><u>235.12.2111</u>   | 17 INFORMANT ADDRESS<br><u>Hallie L. Hawkins (Wife) same as 13</u>  |   |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Ruptured Abdominal Aortic Aneurysm</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> |  |   |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.  |  |   |   |  |  |
| 19a. DATE OF OPERATION<br><u>11-30-84</u>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>Ruptured Aortic Aneurysm</u>   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><u>P.M.</u> <u>19</u>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>11-30</u> , 19 <u>84</u> , to <u>11-30</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>11-30</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                          |  |   |   |  |  |
| 22b. SIGNATURE<br><u>Daniel Wenberg MD</u>  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   | 22c. DATE SIGNED<br><u>11-30-84</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>DANIEL WENBERG</u>  |  | 22e. ADDRESS<br><u>3001 S. HANOVER ST</u>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Burial</u>   | 23b. DATE<br><u>Dec. 4, 1984</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Glen Haven Mem Pk</u>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Glen Burnie A.A. MD</u>             |  |
| 24. FUNERAL DIRECTOR<br>NAME <u>H B Benson</u> ADDRESS <u></u>  |  | 25a. DATE REC'D. BY REGISTRAR<br><u>DEC 4 1984</u>  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Davidson-Randall</u>                                |  |
| Singleton Funeral Home, Glen Burnie, MD   |  |   |   |  |  |

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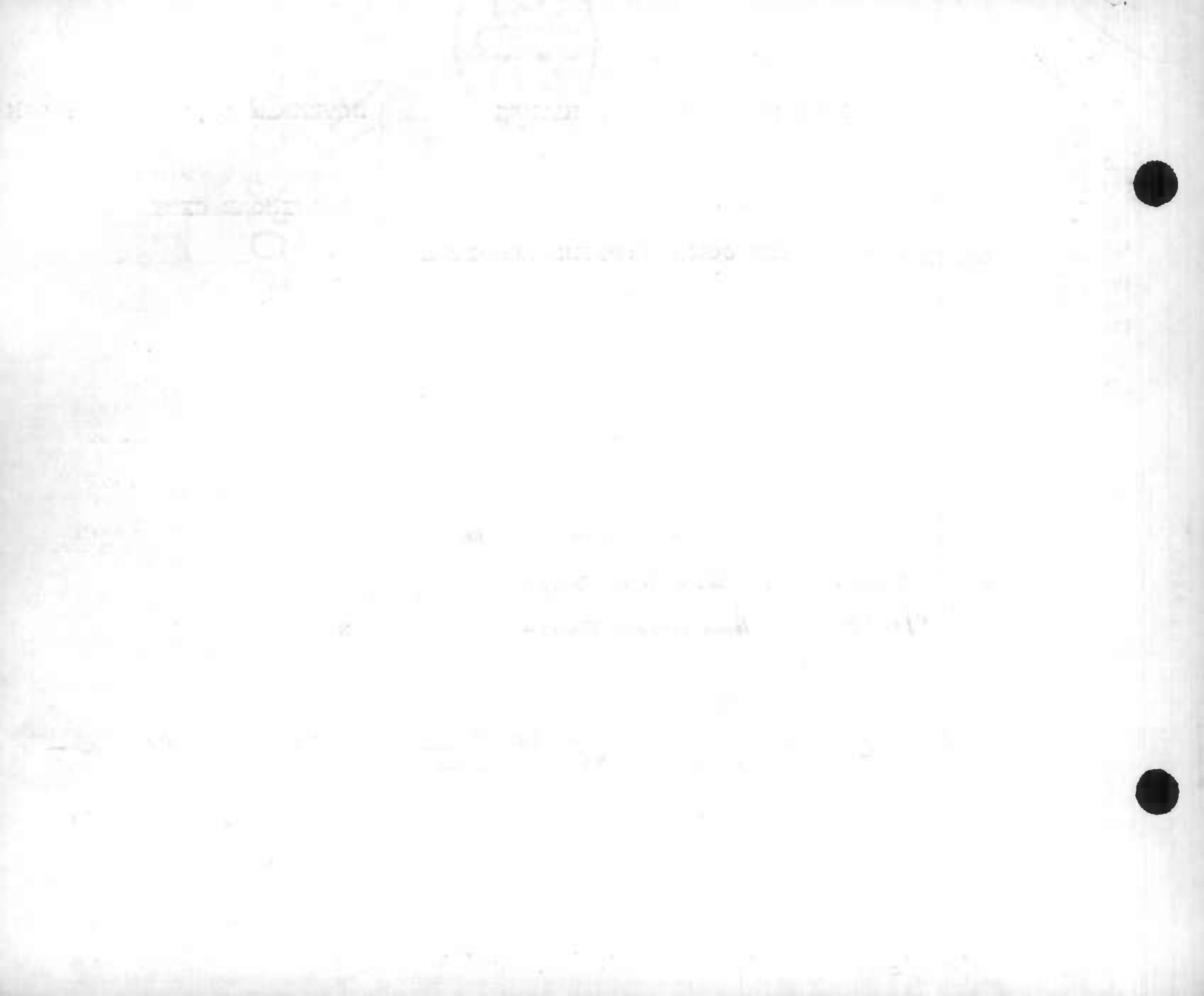


STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1- FOR STATE REGISTRAR<br><b>LILLIAN BAKER HAYMES</b>   |  | 2a. DATE OF DEATH<br><b>NOVEMBER 14 1984</b>   |  | 2b. HOUR<br><b>08:05AM</b>  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>LILLIAN BAKER HAYMES</b>  |  | 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  |
| 5. DATE OF BIRTH<br><b>Jan. 21, 1906</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b>   |  | 7. UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b>   |  | 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b>                 |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |  | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>                               |  |
| 13b. CITY OR TOWN<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Catonsville</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 13e. STREET ADDRESS / ZIP CODE<br><b>434 Greenlow Road 21228</b>  |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Harry Baker</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Alice Reed</b>  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>212-07-5050</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Thomas W. Haymes Same as # 13</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>CARDIOVASCULAR UNRESPONSIVENESS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CARDIOGENIC SHOCK</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ACUTE PEA FAILURE</b> |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 MIN</b><br><b>2 HRS</b><br><b>2 DAYS</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a.<br><b>ATHEROSCLEROTIC ARTERIO SCLEROTIC DISEASE</b>   |  |  |  |   |  |
| 19a. DATE OF OPERATION<br><b>11/12/84</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>ARTERIO ENTERIC FISTULA</b>   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  | 22a. I certify that (I) this hospital attended the deceased from <b>11/14/84</b> to <b>11/14/84</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>11/14/84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |
| 22b. SIGNATURE<br><b>Robert S. Casale</b>   |  | DEGREE<br><b>CASALE</b>  |  | 22c. DATE SIGNED<br><b>11/14/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CASALE</b>  |  | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11/17/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lovettsville Cemetery</b>  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Lovettsville Loudon Virginia</b>   |  | 24. FUNERAL DIRECTOR<br><b>Leroy M. &amp; Russell C. Witzke Funeral Homes P.A.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 15 1984</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>John H. Harrison-Randall</b>   |  | 25c. REGISTRAR'S SIGNATURE   |  |   |  |

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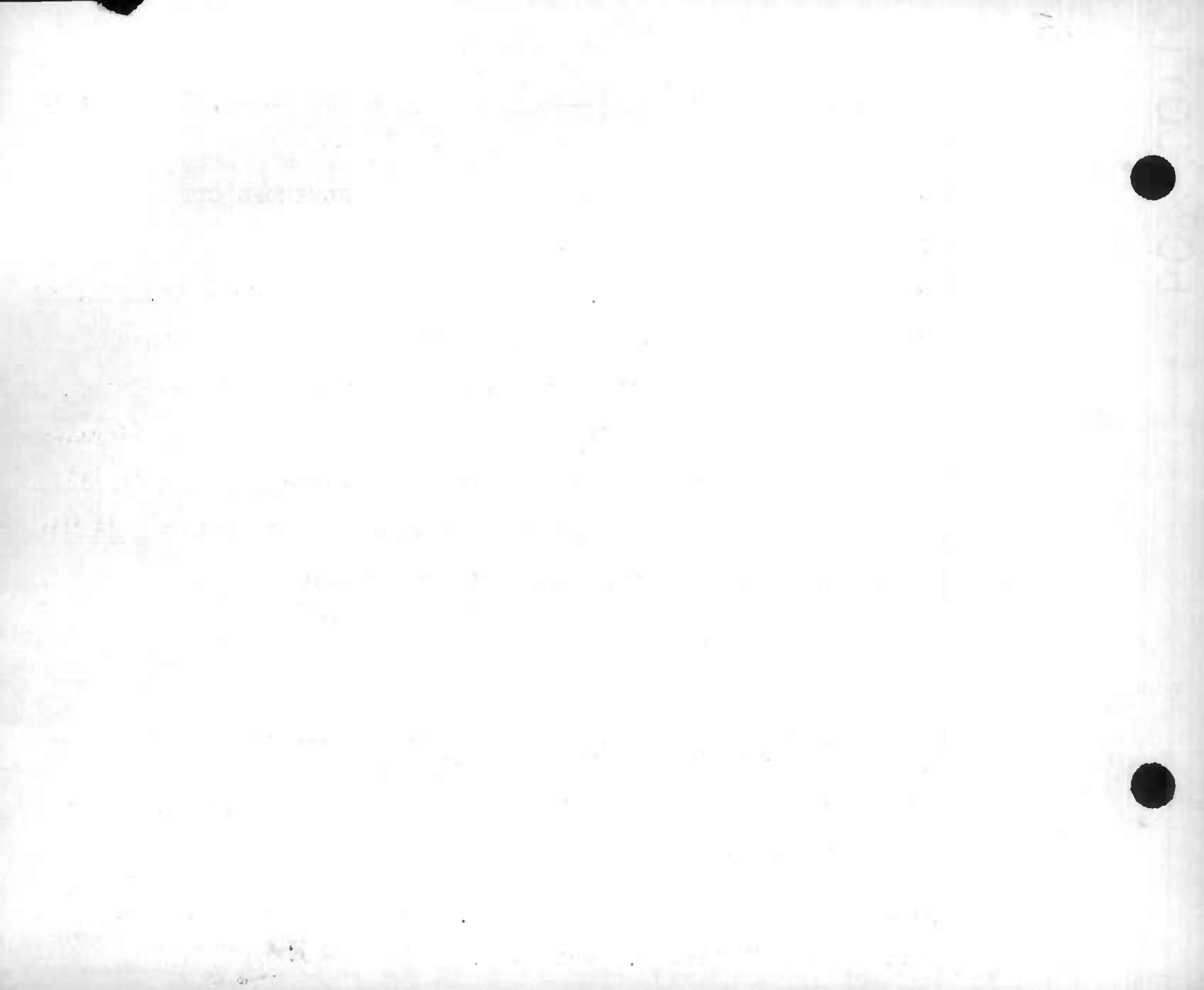


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  | REG. NO.  |  |
|---|--|--|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>HENRY C. HEARD</b>  |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 12, 1984</b>                                 |  |  |  | 2b. HOUR<br><b>7:51 PM</b>  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 3 10</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Ga.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |   |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>1400 Madison St. Apt. 608</b>   |  | <b>21205</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Will Heard</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Hallie Walker</b>   |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>253-01-6890</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Verna Eason 4902 Lock Raven Blvd.</b>                            |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC TAMPONADE</b>   |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>30 min.</b>  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ACUTE MYOCARDIAL INFARCTION</b>  |  |  |  |   |  |   |  |  |  | <b>19 hrs.</b>  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ATHEROSCLEROTIC CORONARY VASCULAR DISEASE</b>  |  |  |  |   |  |   |  |  |  | <b>15 yrs.</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><b>HYPERTENSION, CONGESTIVE HEART FAILURE</b>   |  |  |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July 19 82</b> to <b>Nov 12 84</b> , that (I) (we) lost<br>saw the deceased alive on <b>Nov 12 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Ralph Althouse</b>   |  |  |  |   |  | DEGREE<br><b>MD.</b>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>12 Nov 84.</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RALPH ALTHOUSE</b>  |  |  |  |   |  | 22e. ADDRESS  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  |  | 23b. DATE<br><b>11-19-84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Park</b>                                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arbutus, Md.</b>  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H 1101 E. North Ave.</b>  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 15 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson</b>   |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR aka/ Alice Hearn

REG. NO.

|   |  |   |   |   |  |  |   |  |  |  |  |  |
|---|--|---|---|---|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Alice Hearn  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 26, 1984            |   |  | 2b. HOUR<br>M  |   |  |  |  |  |  |
| 3. SEX<br>female  |  | 4. RACE<br>white  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12/8/93   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>90 YRS  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |  | 8. IF UNDER 24 HRS<br>HOURS MIN.                             |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3675 McTavish Avenue |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Fur Finisher     |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Garment |  |  |  |
| 13a. STATE<br>Maryland  |  |   | 13b. COUNTY<br>Baltimore  |   | 13c. CITY OR TOWN<br>Baltimore                             |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET ADDRESS / ZIP CODE<br>3675 McTavish Avenue 21229 |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Calabe Rufus DeShields  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Sally Jane Darby   |  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>N/A   |  |   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>237-26-7442  |  | 17. INFORMANT ADDRESS<br>Mrs. Marianne Metcalf 3675 McTavish Avenue                  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Anemic. Anoxia.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Respiratory Sideroblastic Anemia.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 years- |  |   |   |   |  |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>Arteriosclerotic Cardiovascular Disease   |  |   |   |   |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19          |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)        |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-20 19 78 to 10-12 19 84, that (I) (we) last saw the deceased alive on 10-12 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>Dr. Alejandro Mejia, M.D.   |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |  |   | 22c. DATE SIGNED   |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Alejandro Mejia, M.D.  |  |   |   | 22e. ADDRESS<br>405 Frederick Road 21228  |  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |   | 23b. DATE<br>11/30/84   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cemetery |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore City, Maryland   |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Ambrose Funeral Home 1328 Sulphur Spring Rd.  |  |   |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 28 1984   |   |  | 25b. REGISTRAR'S SIGNATURE<br>John Davidson  |  |  |  |

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 9 0 2

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |   |   |  |
|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>CLAUDIUS LEE HEATER</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 14 1984</b>                              |   | 2b. HOUR<br><b>9:45AM</b>  |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JULY 10 1922</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>W. VA.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                           |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>WATERFRONT GUARD</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AMERICAN SHIP SERVICE</b>                               |  |
| 13a. STATE<br><b>MD.</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>3806 PINEDALE DR. 21236</b> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>                             |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>232-22-3683</b>  |   | 17. INFORMANT<br><b>DOROTHY HEATER (WIFE)</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Coronary artery disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Myocardial infarction in 1983</b><br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Myocardial infarction in 1983</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>Immediate</b><br><b>years</b>   |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/22</b> , 19 <b>83</b> , to <b>11/07</b> , 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>11/07/84</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |
| 22b. SIGNATURE<br><b>Gary Walford</b>   |  | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input type="checkbox"/> |   | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. GARY WALFORD</b>  |  | 22e. ADDRESS<br><b>FRANKLIN SQUARE HOSP.</b>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>11/16/84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LAKEVIEW MEM. PARK</b>                                 |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MD.</b>  |  |   |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SCHIMUNEK FUNERAL HOME, INC.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 19 1984</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                                     |  |
| ADDRESS<br><b>9705 Belair Rd., Baltimore, Md.</b>   |  |   |   |   |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 29903

|  |  |  |  |   |  |   |  |   |  |                     |  |  |  |                    |  |   |  |  |  |
|--|--|--|--|---|--|---|--|---|--|---------------------|--|--|--|--------------------|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 2. DECEASED NAME<br>(TYPE OR PRINT) <b>ANNA M. HEATHCOTE</b> |  |   |  |   |  |   |  |                     |  | 3. DATE KNOWN<br>OF DEATH <input checked="" type="checkbox"/> ESTI-<br>MATED <input type="checkbox"/> <b>11-5-84</b> |  | 4. MONTH DAY YEAR  |  | 5. HOUR   |  |  |  |
| 3. SEX <b>Female</b>   |  | 4. RACE <b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>2-22-1905</b>   |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY) <b>79</b> YRS. |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.   |  | 8. IF UNDER 24 HRS. |  | 9. DATE<br>PRONOUNCED<br>DEAD <b>11-5-84</b>   |  | 10. MONTH DAY YEAR |  | 11. HOUR <b>9:55A</b>                               |  |  |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY) <b>England</b>  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                     |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>  |  |                    |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br><b>1025 Boyd Street - 21223</b> |  |   |  |   |  |                     |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE) <b>Housewife</b>                                    |  |                    |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY <b>at home</b> |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   |  |   |  |   |  |                     |  |  |  |                    |  |   |  |  |  |
| 13a. STATE <b>Ind</b>  |  |  |  | 13b. COUNTY <b>-</b>  |  |   |  | 13c. CITY OR TOWN <b>Balto.</b>   |  |                     |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                      |  |                    |  | 13e. STREET ADDRESS<br><b>1025 Boyd St. 21223</b>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>? Ryan</b>   |  |  |  |   |  |   |  |   |  |                     |  |  |  |                    |  |   |  |  |  |
| 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Salie Cook</b>  |  |  |  |   |  |   |  |   |  |                     |  |  |  |                    |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>NO</b>  |  |  |  |   |  |   |  |   |  |                     |  |  |  |                    |  |   |  |  |  |
| 16b. SOCIAL SECURITY NO. <b>-</b>  |  |  |  |   |  |   |  |   |  |                     |  |  |  |                    |  |   |  |  |  |
| 17. INFORMANT <b>Tom Heathcote</b> ADDRESS <b>3551 Chesterfield Ave 21213</b>  |  |  |  |   |  |   |  |   |  |                     |  |  |  |                    |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |  |  |   |  |   |  |   |  |                     |  |  |  |                    |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH     |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |  |  |   |  |   |  |   |  |                     |  |  |  |                    |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |   |  |   |  |   |  |                     |  |  |  |                    |  |   |  |  |  |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |   |  |   |  |   |  |                     |  |  |  |                    |  |   |  |  |  |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |   |  |   |  |   |  |                     |  |  |  |                    |  |   |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |                     |  |  |  |                    |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)                              |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |                     |  |  |  |                    |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion<br>death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |  |   |  |   |  |   |  |                     |  |  |  |                    |  |   |  |  |  |
| ACTUAL SIGNATURE <b>Margarita A. Korell</b> TITLE (SPECIFY) <b>M.D. Assistant</b> MEDICAL EXAMINER DATE SIGNED <b>11-5-84</b>  |  |  |  |   |  |   |  |   |  |                     |  |  |  |                    |  |   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b> ADDRESS <b>111 Penn Street</b>  |  |  |  |   |  |   |  |   |  |                     |  |  |  |                    |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>   |  |  |  | 23b. DATE <b>11-8-1984</b>  |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Eden Hill Cem.</b>  |  |                     |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Elkton Pk. G.G. Co. Ind.</b>   |  |                    |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>John J. Cowan &amp; Son, Inc.</b> ADDRESS <b>Balto. 21223</b> 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE   |  |  |  |   |  |   |  |   |  |                     |  |  |  |                    |  |   |  |  |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

NOV 09 1984





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OFFICE OF THE SECRETARY OF THE ARMY

UNITED STATES

ARMY

OFFICE OF THE SECRETARY OF THE ARMY



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JAN 10 1941

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 9 0 4

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |
|---|--|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>1 (MARTY) (L) M. (HEBRON)</b>  |  | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>3</b> YEAR <b>84</b>  |  | 2b. HOUR<br><b>10<sup>15</sup> PM</b>   |
| 3. SEX<br><b>FEMALE</b>   | 4. RACE<br><b>B.</b>   | 5. DATE OF BIRTH<br>MONTH <b>08</b> DAY <b>06</b> YEAR <b>12</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS.   |
| 7a. BIRTHPLACE<br>COUNTRY <b>MD</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Mt. Vernon Care Center</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |   |
| 13a. STATE<br><b>MD.</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST <b>Thomas</b> MIDDLE <b>Carey</b> LAST <b>Carey</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Irene</b> MIDDLE <b>Chester</b> LAST <b>Chester</b>  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>UNKNOWN</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>220-18-6934</b>  |  | 17. INFORMANT<br><b>Leonard A. Sanders</b> ADDRESS <b>5647 Lothian Rd.</b>                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS, 101 Lung</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>METASTASIS BRAIN</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)      |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>POST RADIATION, PNEUMONIA, pleural effusion</b>   |  |   |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19 <b>84</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/01</b> , 19 <b>84</b> , to <b>11/03</b> , 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>11/03</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |
| 22b. SIGNATURE<br><b>A. Enriquez</b>  |  | DEGREE<br><b>ATTENDING PHYSICIAN</b>  |  | 22c. DATE SIGNED<br><b>11/5/84</b>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A. C. ENRIQUEZ MD</b>   |  | 22e. ADDRESS<br><b>2435 W BELVEDERE 21215</b>   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |  | 23b. DATE<br><b>11/7/84</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Calvary Cem.</b>    |   |
| 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>Co.</b> STATE <b>MD</b>  |  | 23e. DATE REC'D. BY REGISTRAR <b>NOV 7 1984</b>   |  |   |
| 24. FUNERAL DIRECTOR<br>NAME <b>Wm. C. March F/H</b> ADDRESS <b>1101 E. North Ave.</b>  |  | 25. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |   |

BP.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the deceased was not retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10

March 15, 1900  
To the Hon. Sec. of the Interior  
Washington, D. C.

Dear Sir:  
I have the honor to acknowledge the receipt of your letter of the 14th inst. in relation to the application of the National Park Commission for the purchase of the land in the State of California.

I am sorry to hear that the Commission is unable to purchase the land. I am sure that the Government will do all in its power to protect the public interest.

I am, Sir, very respectfully,  
Your obedient servant,  
J. C. Smith

Very truly yours,  
J. C. Smith

11/15/00  
J. C. Smith

11/15/00  
J. C. Smith

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

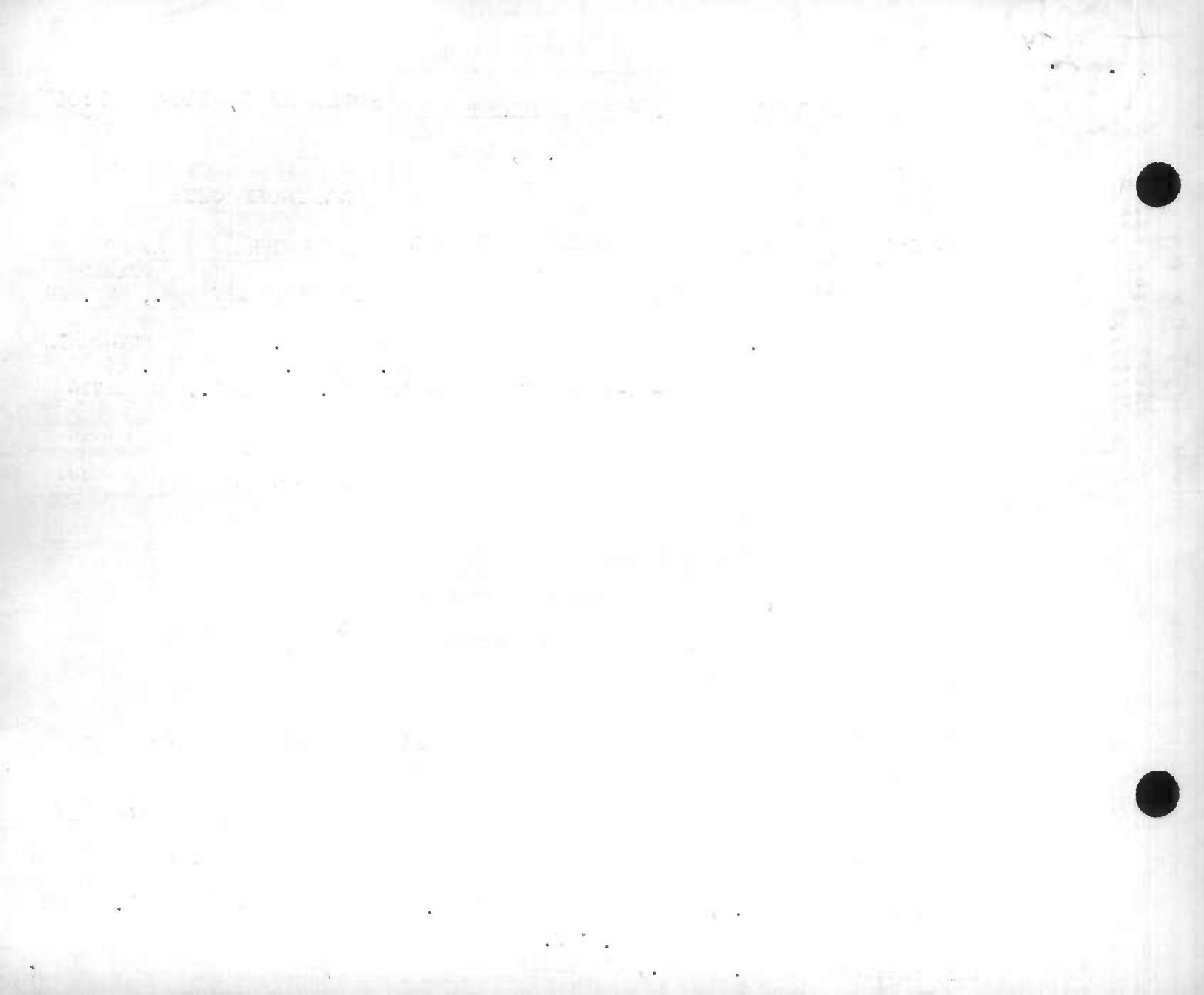
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

MEDICAL CERTIFICATION

|  |  |   |  |   |  |   |  |  |  |  |  |
|--|--|---|--|---|--|---|--|--|--|--|--|
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |  | 8 4 2 9 9 0 5  |  |
| 1. FOR STATE REGISTRAR   |  | REG. NO.  |  |   |  |   |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>MARGARET M. OSES HECHT   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>NOVEMBER 1, 1984                        |   |  | 2b. HOUR<br>A M<br>3:00                      |  |  |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>JAN. 9, 1923  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>61 YRS.                                    |  | 7. UNDER 1 YEAR<br>MONTHS DAYS<br>HOURS MIN. |  |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                    |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME |  |  |  |
| 13a. STATE<br>MARYLAND   |  |   |  |   | 13b. COUNTY<br>BALTIMORE   |   | 13c. CITY OR TOWN<br>BALTIMORE   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>HERBERT L. MOSES   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>STELLA R. ROTHSCHILD          |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>006-14-7711  |  | 17. INFORMANT<br>MR. ALAN D. HECHT APT. 66<br>200 CROSS KEYS RD. BALTO., MD 21210   |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>inferior myocardial infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 hour<br>2 days |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____   |  |   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/30</u> , 19 <u>84</u> , to <u>11/1</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased <u>live</u> on <u>11/1</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.                 |  |   |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Peter C. Belitsos</u>   |  |   |  |   | DEGREE<br>MD   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>10/1/84  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Peter C. Belitsos   |  |   |  |   | 22e. ADDRESS<br>601 W. Wolfe St. Baltimore Md. 21214                           |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) BURIAL  |  |   | 23b. DATE<br>NOV. 2, 1984  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>OHEB SHALOM MEM. PARK                    |   |  | 23d. LOCATION<br>REISTERSTOWN BALTO. MD      |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.<br>ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 7 1984                                    |   | 25b. REGISTRAR'S SIGNATURE<br><u>Davidson</u>  |  |  |  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (1))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |         |  |                   |  |   |   |          |   |  |  |  |
|--|---------|--|-------------------|--|---|---|----------|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         |  |                   | 2a. DATE KNOWN OF DEATH  |   |   |          | 2b. HOUR  |  |  |  |
| JOSEPHINE  |         |  |                   | HELTON   |   |   |          | 11-2-84 19  |  |  |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   | 6. AGE (IN YEARS) | IF UNDER 1 YR.   | IF UNDER 24 HRS.  | 7c. DATE PRONOUNCED DEAD  | 2d. HOUR |   |  |  |  |
| Female   | White   | 5 20 23  | 61                |  |   | 11-2-84 19  | 8:02PM   |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?                             |                   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH  |          |   |  |  |  |
| Pennsylvania   |         | U.S.A.   |                   |  |   | Baltimore City  |          |   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |                   |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK)  |          | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |
| Baltimore  |         | Francis Scott Key Medical Center                         |                   |  |   | Presser   |          | Clothing  |  |  |  |
| 13a. STATE   |         |  |                   | 13b. CITY OR TOWN  | 13c. INSIDE CITY LIMITS?  | 13d. STREET ADDRESS   |          |   |  |  |  |
| Maryland   |         |  |                   | Baltimore  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 1219 Anglesea St. 21224   |          |   |  |  |  |
| 14. FATHER'S NAME  |         |  |                   | 15. MOTHER'S MAIDEN NAME   |   |   |          |   |  |  |  |
| John   |         |  |                   | Krawchuk   |   |   |          | Mary Paseluko   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |         |  |                   | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS   |          |   |  |  |  |
| No   |         |  |                   | 183-18-1598  |   | Alonzo Helton Sr. 1219 Anglesea St.   |          |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |  |                   |  |   |   |          |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I DEATH WAS CAUSED BY:  |         |  |                   |  |   |   |          |   |  |  |  |
| IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>   |         |  |                   |  |   |   |          |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |                   |  |   |   |          |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost:  |         |  |                   |  |   |   |          |   |  |  |  |
| (b) _____  |         |  |                   |  |   |   |          |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |                   |  |   |   |          |   |  |  |  |
| (c) _____  |         |  |                   |  |   |   |          |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |         |  |                   |  |   |   |          |   |  |  |  |
| 19a. DATE OF OPERATION   |         |  |                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   |          | 20. AUTOPSY?  |  |  |  |
|  |         |  |                   |  |   |   |          | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         |  |                   | 21b. TIME OF INJURY  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |          |   |  |  |  |
|  |         |  |                   | HOUR A.M. MONTH DAY YEAR   |   |   |          |   |  |  |  |
| 21d. INJURY OCCURRED   |         |  |                   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |   | 21f. LOCATION   |          |   |  |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |         |  |                   |  |   | CITY OR TOWN COUNTY STATE   |          |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural cause</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |  |                   |  |   |   |          |   |  |  |  |
| ACTUAL SIGNATURE   |         |  |                   | TITLE (SPECIFY)  |   |   |          | DATE SIGNED   |  |  |  |
|  |         |  |                   | M.D. Assistant MEDICAL EXAMINER  |   |   |          | 11-3-84   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |         |  |                   | ADDRESS  |   |   |          |   |  |  |  |
| Gregory R. Kauffman, M.D.  |         |  |                   | 111 Penn Street  |   |   |          |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         |  |                   | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY  |          | 23d. LOCATION   |  |  |  |
| Burial   |         |  |                   | 11-6-84  |   | Oak Lawn Cemetery   |          | Eastwood, Balto. Co., Md.   |  |  |  |
| 24. FUNERAL DIRECTOR   |         |  |                   | 25a. DATE REC'D. BY REGISTRAR  |   |   |          | 25b. REGISTRAR'S SIGNATURE  |  |  |  |
| Charles S. Zeiler & Son Inc.   |         |  |                   | NOV 5 1984   |   |   |          | Julia Davidson-Randall  |  |  |  |

2025 COLLECTION



Feb 11 1971

1/11/71  
1/11/71

11-11  
11-11



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 4 2 9 9 0 7   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Everett J. Hennessey</i>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 30 1984   |  | 2b. HOUR<br>11:25 AM   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 19 1910   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Francis Scott Key Med.Center |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Roll Grinder  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Beth. Steel   |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Dundalk  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Benjamin Hennessey  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Laura Groves   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   IF YES, GIVE WAR OR DATES<br>NO  |  |  |  |
| 16b. SOCIAL SECURITY NO.<br>213-07-2886   |  | 17. INFORMANT<br>Wilma Burns  |  | ADDRESS<br>Same as 13e  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>cardiac arrest</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>myo cardial infarction.</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>ASC-40</i> |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11-30</i> , 19 <i>1984</i> , to <i>11-30</i> , 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>19</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                             |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Charles Werdth MD</i>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Charles Werdth</i>  |  |   |  | 22e. ADDRESS<br><i>FSR MC</i>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>12/3/84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Bel Air Mem. Gdns.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Bel Air Harford MD.  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Duda-Ruck, Inc<br>7922 Wise Avenue Dundalk, MD. 21222   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 5 1984   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/B4  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 9 0 8

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>YVONNE J HENSLEY  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 29 84              |   | 2b. HOUR<br>11:30 AM   |   |  |  |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>CAUCASIAN   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 24, 36   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>48 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                     |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore, Md.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Manager                     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Restaurant  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>1417 Washington Blvd. 21230  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Lance Burke   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Nora Norris |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>223-46-8199  |  | 17. INFORMANT<br>ADDRESS<br>Brill Funeral Home Elkton, Virginia   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopolmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>elevated intracranial pressure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>massive intracranial bleed</u> |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>approx 10 min.</u><br><u>15 days</u><br><u>~15 days</u> |  |
|   |  |  |  |   |  |   |  |  |  |
|   |  |  |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><u>CD bacterial peritonitis</u> <u>CD gastrointestinal hemorrhage</u>   |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>26 Nov</u> , 19 <u>84</u> , to <u>29 Nov</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>29 Nov</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Mitchell Howard Weiss, MD   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br>11/29/84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Mitchell Howard Weiss  |  |  |  | 22e. ADDRESS<br>22 So. Green St. Pott, MD 21201   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>Dec. 2, 1984  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Elk Run Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Elkton, Virginia                                  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Ruck Towson Funeral Home, Inc. Towson, Md. 21204  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 30 1984  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |  |  |

MEDICAL CERTIFICATION

A

Blank lined paper with faint horizontal lines and a circular stamp on the left side.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 9 0 9

REG. NO.

|  |  |  |   |  |   |  |
|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>HOWARD E HENTZ</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 26 84</b>                |  | 2b. HOUR<br><b>8:29 AM</b>  |  |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>W</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 7 22</b>                                 |   |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b> YRS.  |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |   |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.   |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hosp.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |   |  |
| 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |   |  |   |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>BALTO</b>  |   | 13c. CITY OR TOWN<br><b>BALTO</b>  |   |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>3040 Waterview Ave. 21225</b>   |   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Howard Hentz</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lillian Mills</b> |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Unkn.</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)  |   | 17. INFORMANT<br>ADDRESS   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST.</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>ADULT RESPIRATORY DISTRESS SYNDROME</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>PNEUMOCOCCAL PNEUMONIA</b>  |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>5-10 min.</b><br><b>24 hr.</b><br><b>36 hr.</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>HYPERCALCEMIA</b>  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 24</b> , 19 <b>84</b> , to <b>Nov 26</b> , 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>Nov 26</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>P. Kennedy</b>  |  | DEGREE<br><b>MD</b>  |   | 22c. DATE SIGNED<br><b>11/26/84</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>P. KENNEDY, MD.</b>  |  | 22e. ADDRESS<br><b>UMMS</b>  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Removal</b>   |  | 23b. DATE<br><b>11/29/84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY   |   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Anatomy Board</b>   |  | ADDRESS<br><b>Balto., Md.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 03 1984</b>                                  |   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |  |   |  |   |  |

BP

1

OLIVER TIBBETTS  
2111 1910

REC'D 3 JUN 1910

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR<br>1- STATE<br>REGISTRAR  |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 4 2 9 9 1 0<br>REG. NO.   |  |  |  |
|---|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Flemuel Earl HEPBURN</b>   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-27-84</b>  |  |   |  | 2b. HOUR<br><b>1:30 A.M.</b>  |  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 6 1914</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE</b> City MD.                               |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Provident Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Crane Operator</b>       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Bethlehem Steel</b>                       |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3323 Mondawmin Avenue<br/>Baltimore, Maryland 21216</b> |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Mence Hepburn</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rosa Tisdale</b>  |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II 072-10-2026</b>  |  | 17. INFORMANT<br><b>Janice E. Hepburn</b>   |  |   |  | 3323 Mondawmin Avenue<br>Baltimore, Maryland 21216                                |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMA OF LUNG</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>PNEUMONIA</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>CONGESTIVE HEART FAILURE</b> |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>CONGESTIVE HEART FAILURE</b>  |  |  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>         |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)                  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-26-84</b> , 19 <b>84</b> , to <b>11-27-84</b> , 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>11-27-84</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.    |  |  |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>K. Mathur</b>  |  |  |  | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><b>11-27-84</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>K. MATHUR</b>   |  |  |  | 22e. ADDRESS<br><b>2600 Liberty Hts. Ave<br/>Baltimore 21215</b>  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>12/1/1984</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                        |  |   |  |  |  |
| 24. FUNERAL HOME OR<br>NAME ADDRESS<br><b>Nutter &amp; Sons<br/>2501 Gwynns Falls Parkway<br/>Funeral Home Inc. Baltimore, Maryland 21216</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 30 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Jana Davidson-Randall</b>                                      |  |   |  |  |  |





DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

29911

|                        |  |   |  |   |  |   |  |   |  |   |  |   |  |   |  |   |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |    |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  |     |  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| 1- FOR STATE REGISTRAR |  | 2 |  | 3 |  | 4 |  | 5 |  | 6 |  | 7 |  | 8 |  | 9 |  | 10 |  | 11 |  | 12 |  | 13 |  | 14 |  | 15 |  | 16 |  | 17 |  | 18 |  | 19 |  | 20 |  | 21 |  | 22 |  | 23 |  | 24 |  | 25 |  | 26 |  | 27 |  | 28 |  | 29 |  | 30 |  | 31 |  | 32 |  | 33 |  | 34 |  | 35 |  | 36 |  | 37 |  | 38 |  | 39 |  | 40 |  | 41 |  | 42 |  | 43 |  | 44 |  | 45 |  | 46 |  | 47 |  | 48 |  | 49 |  | 50 |  | 51 |  | 52 |  | 53 |  | 54 |  | 55 |  | 56 |  | 57 |  | 58 |  | 59 |  | 60 |  | 61 |  | 62 |  | 63 |  | 64 |  | 65 |  | 66 |  | 67 |  | 68 |  | 69 |  | 70 |  | 71 |  | 72 |  | 73 |  | 74 |  | 75 |  | 76 |  | 77 |  | 78 |  | 79 |  | 80 |  | 81 |  | 82 |  | 83 |  | 84 |  | 85 |  | 86 |  | 87 |  | 88 |  | 89 |  | 90 |  | 91 |  | 92 |  | 93 |  | 94 |  | 95 |  | 96 |  | 97 |  | 98 |  | 99 |  | 100 |  | 101 |  | 102 |  | 103 |  | 104 |  | 105 |  | 106 |  | 107 |  | 108 |  | 109 |  | 110 |  | 111 |  | 112 |  | 113 |  | 114 |  | 115 |  | 116 |  | 117 |  | 118 |  | 119 |  | 120 |  | 121 |  | 122 |  | 123 |  | 124 |  | 125 |  | 126 |  | 127 |  | 128 |  | 129 |  | 130 |  | 131 |  | 132 |  | 133 |  | 134 |  | 135 |  | 136 |  | 137 |  | 138 |  | 139 |  | 140 |  | 141 |  | 142 |  | 143 |  | 144 |  | 145 |  | 146 |  | 147 |  | 148 |  | 149 |  | 150 |  | 151 |  | 152 |  | 153 |  | 154 |  | 155 |  | 156 |  | 157 |  | 158 |  | 159 |  | 160 |  | 161 |  | 162 |  | 163 |  | 164 |  | 165 |  | 166 |  | 167 |  | 168 |  | 169 |  | 170 |  | 171 |  | 172 |  | 173 |  | 174 |  | 175 |  | 176 |  | 177 |  | 178 |  | 179 |  | 180 |  | 181 |  | 182 |  | 183 |  | 184 |  | 185 |  | 186 |  | 187 |  | 188 |  | 189 |  | 190 |  | 191 |  | 192 |  | 193 |  | 194 |  | 195 |  | 196 |  | 197 |  | 198 |  | 199 |  | 200 |  | 201 |  | 202 |  | 203 |  | 204 |  | 205 |  | 206 |  | 207 |  | 208 |  | 209 |  | 210 |  | 211 |  | 212 |  | 213 |  | 214 |  | 215 |  | 216 |  | 217 |  | 218 |  | 219 |  | 220 |  | 221 |  | 222 |  | 223 |  | 224 |  | 225 |  | 226 |  | 227 |  | 228 |  | 229 |  | 230 |  | 231 |  | 232 |  | 233 |  | 234 |  | 235 |  | 236 |  | 237 |  | 238 |  | 239 |  | 240 |  | 241 |  | 242 |  | 243 |  | 244 |  | 245 |  | 246 |  | 247 |  | 248 |  | 249 |  | 250 |  | 251 |  | 252 |  | 253 |  | 254 |  | 255 |  | 256 |  | 257 |  | 258 |  | 259 |  | 260 |  | 261 |  | 262 |  | 263 |  | 264 |  | 265 |  | 266 |  | 267 |  | 268 |  | 269 |  | 270 |  | 271 |  | 272 |  | 273 |  | 274 |  | 275 |  | 276 |  | 277 |  | 278 |  | 279 |  | 280 |  | 281 |  | 282 |  | 283 |  | 284 |  | 285 |  | 286 |  | 287 |  | 288 |  | 289 |  | 290 |  | 291 |  | 292 |  | 293 |  | 294 |  | 295 |  | 296 |  | 297 |  | 298 |  | 299 |  | 300 |  | 301 |  | 302 |  | 303 |  | 304 |  | 305 |  | 306 |  | 307 |  | 308 |  | 309 |  | 310 |  | 311 |  | 312 |  | 313 |  | 314 |  | 315 |  | 316 |  | 317 |  | 318 |  | 319 |  | 320 |  | 321 |  | 322 |  | 323 |  | 324 |  | 325 |  | 326 |  | 327 |  | 328 |  | 329 |  | 330 |  | 331 |  | 332 |  | 333 |  | 334 |  | 335 |  | 336 |  | 337 |  | 338 |  | 339 |  | 340 |  | 341 |  | 342 |  | 343 |  | 344 |  | 345 |  | 346 |  | 347 |  | 348 |  | 349 |  | 350 |  | 351 |  | 352 |  | 353 |  | 354 |  | 355 |  | 356 |  | 357 |  | 358 |  | 359 |  | 360 |  | 361 |  | 362 |  | 363 |  | 364 |  | 365 |  | 366 |  | 367 |  | 368 |  | 369 |  | 370 |  | 371 |  | 372 |  | 373 |  | 374 |  | 375 |  | 376 |  | 377 |  | 378 |  | 379 |  | 380 |  | 381 |  | 382 |  | 383 |  | 384 |  | 385 |  | 386 |  | 387 |  | 388 |  | 389 |  | 390 |  | 391 |  | 392 |  | 393 |  | 394 |  | 395 |  | 396 |  | 397 |  | 398 |  | 399 |  | 400 |  | 401 |  | 402 |  | 403 |  | 404 |  | 405 |  | 406 |  | 407 |  | 408 |  | 409 |  | 410 |  | 411 |  | 412 |  | 413 |  | 414 |  | 415 |  | 416 |  | 417 |  | 418 |  | 419 |  | 420 |  | 421 |  | 422 |  | 423 |  | 424 |  | 425 |  | 426 |  | 427 |  | 428 |  | 429 |  | 430 |  | 431 |  | 432 |  | 433 |  | 434 |  | 435 |  | 436 |  | 437 |  | 438 |  | 439 |  | 440 |  | 441 |  | 442 |  | 443 |  | 444 |  | 445 |  | 446 |  | 447 |  | 448 |  | 449 |  | 450 |  | 451 |  | 452 |  | 453 |  | 454 |  | 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566 |  | 567 |  | 568 |  | 569 |  | 570 |  | 571 |  | 572 |  | 573 |  | 574 |  | 575 |  | 576 |  | 577 |  | 578 |  | 579 |  | 580 |  | 581 |  | 582 |  | 583 |  | 584 |  | 585 |  | 586 |  | 587 |  | 588 |  | 589 |  | 590 |  | 591 |  | 592 |  | 593 |  | 594 |  | 595 |  | 596 |  | 597 |  | 598 |  | 599 |  | 600 |  | 601 |  | 602 |  | 603 |  | 604 |  | 605 |  | 606 |  | 607 |  | 608 |  | 609 |  | 610 |  | 611 |  | 612 |  | 613 |  | 614 |  | 615 |  | 616 |  | 617 |  | 618 |  | 619 |  | 620 |  | 621 |  | 622 |  | 623 |  | 624 |  | 625 |  | 626 |  | 627 |  | 628 |  | 629 |  | 630 |  | 631 |  | 632 |  | 633 |  | 634 |  | 635 |  | 636 |  | 637 |  | 638 |  | 639 |  | 640 |  | 641 |  | 642 |  | 643 |  | 644 |  | 645 |  | 646 |  | 647 |  | 648 |  | 649 |  | 650 |  | 651 |  | 652 |  | 653 |  | 654 |  | 655 |  | 656 |  | 657 |  | 658 |  | 659 |  | 660 |  | 661 |  | 662 |  | 663 |  | 664 |  | 665 |  | 666 |  | 667 |  | 668 |  | 669 |  | 670 |  | 671 |  | 672 |  | 673 |  | 674 |  | 675 |  | 676 |  | 677 |  | 678 |  | 679 |  | 680 |  | 681 |  | 682 |  | 683 |  | 684 |  | 685 |  | 686 |  | 687 |  | 688 |  | 689 |  | 690 |  | 691 |  | 692 |  | 693 |  | 694 |  | 695 |  | 696 |  | 697 |  | 698 |  | 699 |  | 700 |  | 701 |  | 702 |  | 703 |  | 704 |  | 705 |  | 706 |  | 707 |  | 708 |  | 709 |  | 710 |  | 711 |  | 712 |  | 713 |  | 714 |  | 715 |  | 716 |  | 717 |  | 718 |  | 719 |  | 720 |  | 721 |  | 722 |  | 723 |  | 724 |  | 725 |  | 726 |  | 727 |  | 728 |  | 729 |  | 730 |  | 731 |  | 732 |  | 733 |  | 734 |  | 735 |  | 736 |  | 737 |  | 738 |  | 739 |  | 740 |  | 741 |  | 742 |  | 743 |  | 744 |  | 745 |  | 746 |  | 747 |  | 748 |  | 749 |  | 750 |  | 751 |  | 752 |  | 753 |  | 754 |  | 755 |  | 756 |  | 757 |  | 758 |  | 759 |  | 760 |  | 761 |  | 762 |  | 763 |  | 764 |  | 765 |  | 766 |  | 767 |  | 768 |  | 769 |  | 770 |  | 771 |  | 772 |  | 773 |  | 774 |  | 775 |  | 776 |  | 777 |  | 778 |  | 779 |  | 780 |  | 781 |  | 782 |  | 783 |  | 784 |  | 785 |  | 786 |  | 787 |  | 788 |  | 789 |  | 790 |  | 791 |  | 792 |  | 793 |  | 794 |  | 795 |  | 796 |  | 797 |  | 798 |  | 799 |  | 800 |  | 801 |  | 802 |  | 803 |  | 804 |  | 805 |  | 806 |  | 807 |  | 808 |  | 809 |  | 810 |  | 811 |  | 812 |  | 813 |  | 814 |  | 815 |  | 816 |  | 817 |  | 818 |  | 819 |  | 820 |  | 821 |  | 822 |  | 823 |  | 824 |  | 825 |  | 826 |  | 827 |  | 828 |  | 829 |  | 830 |  | 831 |  | 832 |  | 833 |  | 834 |  | 835 |  | 836 |  | 837 |  | 838 |  | 839 |  | 840 |  | 841 |  | 842 |  | 843 |  | 844 |  | 845 |  | 846 |  | 847 |  | 848 |  | 849 |  | 850 |  | 851 |  | 852 |  | 853 |  | 854 |  | 855 |  | 856 |  | 857 |  | 858 |  | 859 |  | 860 |  | 861 |  | 862 |  | 863 |  | 864 |  | 865 |  | 866 |  | 867 |  | 868 |  | 869 |  | 870 |  | 871 |  | 872 |  | 873 |  | 874 |  | 875 |  | 876 |  | 877 |  | 878 |  | 879 |  | 880 |  | 881 |  | 882 |  | 883 |  | 884 |  | 885 |  | 886 |  | 887 |  | 888 |  | 889 |  | 890 |  | 891 |  | 892 |  | 893 |  | 894 |  | 895 |  | 896 |  | 897 |  | 898 |  | 899 |  | 900 |  | 901 |  | 902 |  | 903 |  | 904 |  | 905 |  | 906 |  | 907 |  | 908 |  | 909 |  | 910 |  | 911 |  | 912 |  | 913 |  | 914 |  | 915 |  | 916 |  | 917 |  | 918 |  | 919 |  | 920 |  | 921 |  | 922 |  | 923 |  | 924 |  | 925 |  | 926 |  | 927 |  | 928 |  | 929 |  | 930 |  | 931 |  | 932 |  | 933 |  | 934 |  | 935 |  | 936 |  | 937 |  | 938 |  | 939 |  | 940 |  | 941 |  | 942 |  | 943 |  | 944 |  | 945 |  | 946 |  | 947 |  | 948 |  | 949 |  | 950 |  | 951 |  | 952 |  | 953 |  | 954 |  | 955 |  | 956 |  | 957 |  | 958 |  | 959 |  | 960 |  | 961 |  | 962 |  | 963 |  | 964 |  | 965 |  | 966 |  | 967 |  | 968 |  | 969 |  | 970 |  | 971 |  | 972 |  | 973 |  | 974 |  | 975 |  | 976 |  | 977 |  | 978 |  | 979 |  | 980 |  | 981 |  | 982 |  | 983 |  | 984 |  | 985 |  | 986 |  | 987 |  | 988 |  | 989 |  | 990 |  | 991 |  | 992 |  | 993 |  | 994 |  | 995 |  | 996 |  | 997 |  | 998 |  | 999 |  | 1000 |  | 1001 |  | 1002 |  | 1003 |  | 1004 |  | 1005 |  | 1006 |  | 1007 |  | 1008 |  | 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1901

NOV 10



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 8429912

|   |  |  |   |   |                     |   |  |  |  |   |  |
|---|--|--|---|---|---------------------|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>WOODROW LANTY HEROLD  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>NOV. 24 1984 |   | 2b. HOUR<br>6 P. M. |   |  |  |  |   |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>WHITE   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>JAN. 27 1913  |                     | 6. AGE (IN YEARS (LAST BIRTHDAY))<br>71 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  | 8. IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>W. VA.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3236 BRENDAN AVENUE |   |   |                     | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SPECIALIST                  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>FED. GOV'T  |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |   |   |                     |   |  |  |  |   |  |
| 13a. STATE<br>MD.   |  | 13b. COUNTY<br>-   |   | 13c. CITY OR TOWN<br>BALTIMORE  |                     | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>3236 BRENDAN AVE. 21213  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>ANDREW HEROLD   |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>GRACE GUN  |                     |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>YES WW II   |  |  |   | 16b. SOCIAL SECURITY NO.<br>235-16-9612   |                     | 17. INFORMANT<br>ADDRESS<br>CLARA HEROLD (WIFE) SAME ADDRESS                                    |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) ADENOCARCINOMA OF LUNG<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |   |   |                     |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>6 MONTHS   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |  |   |   |                     |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                     |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                     | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from MAY 1984, to November 1984, that (I) (we) lost<br>saw the deceased alive on October 25th 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |                     |   |  |  |  |   |  |
| 22b. SIGNATURE<br>Ian N Oliver  |  |  |   | DEGREE<br>MD  |                     |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>11/26/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. IAN OLIVER   |  |  |   | 22e. ADDRESS<br>UNIVERSITY HOSPITAL   |                     |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>REMOVAL   |  |  |   | 23b. DATE<br>11/28/84   |                     | 23c. NAME OF CEMETERY OR CREMATORY<br>MONTEREY CEMETERY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>MONTEREY VA.   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME SCHIMUNEK FUNERAL HOME, INC.<br>3331 Brehms Lane, Balto. Md. 21213   |  |  |   |   |                     | 25a. DATE REC'D. BY REGISTRAR<br>NOV 27 1984  |  | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randall  |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 4 2 9 9 1 3   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>JOHN F. HETTICHE</i>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>11-3-84</i>  |  |   |  | 2b. HOUR<br><i>5:40 A.M.</i>   |  |
| 3. SEX<br><i>Male</i>  |  | 4. RACE<br><i>White</i>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>11-11-1943</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>40</i> YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><i>Ind.</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City MD.</i>                               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Univ. of Md. Hospital</i> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Painter</i>              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Coast. Co.</i>   |  |
| 13a. STATE<br><i>Md.</i>   |  | 13b. COUNTY<br><i>-</i>   |  | 13c. CITY OR TOWN<br><i>Baltimore</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><i>1228 Sargent St. 21223</i>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>Henry Hettiche</i>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Betha Yowell</i>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>213-42-3846</i>   |  | 17. INFORMANT ADDRESS<br><i>Rose Maurer 908 Ramsay St. 21223</i>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <i>Hypertension</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE <i>A. Sri Kumpo L</i> DEGREE  |  |   |  | 22c. DATE SIGNED<br><i>11-5-84</i>  |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>A. SRI KUMPO L</i>   |  |   |  | 22e. ADDRESS<br><i>788 WASHINGTON ST. BALTIMORE 21230</i>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>11-7-1984</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Green Hill</i>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore City Md.</i>                         |  |  |  |
| 24. FUNERAL DIRECTOR<br><i>Green &amp; Sons, Inc. 901 Hillman St.</i>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>NOV 07 1984</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>John D. ...</i>  |  |  |  |

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page # \_\_\_\_\_

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



REER

POW

*[Faint, mostly illegible handwritten text and markings across the page, possibly including dates and names.]*

... ..



Item 4 p. 11/26/84

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 4 2 9 9 1 4  
CERTIFICATE OF DEATH

REG. NO.

|   |   |   |   |  |   |  |
|---|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>MARTHA S. HETTCHEN</b>  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11-16-84</b> |  | 2b. HOUR<br><b>10<sup>30</sup> A M</b>  |  |
| 3. SEX<br><b>F</b>  | 4. RACE<br><b>white</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4-1-31</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>53</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MISS, USA</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY</b> MD.  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIV. OF MD CANCER CENTER</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Registered Nurse</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>md.</b>  |   |   | 13b. COUNTY<br><b>Howard</b>                        | 13c. CITY OR TOWN<br><b>Ellicott City</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>8417 ELK DR. 21043</b>  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>MARIO Y. MONTGOMERY</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>LURA BOONE</b>  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>856-9 428-52-6347</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Henry E. Hettchen - husband</b>   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>SEVERE METABOLIC ACIDOSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>LIVER FAILURE VS. SEPSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>METASTATIC BREAST CANCER</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH<br><b>CONTRIBUTING TO DEATH</b> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.  |   |   |   |  |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |  |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/7/84</b> to <b>11/16</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>11/16</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |   |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Carla S. Alexander, MD</b>   |   |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>11/16/84</b>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CARLA S. ALEXANDER</b>  |   |   |   | 22e. ADDRESS<br><b>UNIV. OF MD CANCER CENTER</b>   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |   | 23b. DATE<br><b>11/19/84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PARKWOOD CEMETERY</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>PARKWOOD BALTO., MD</b>   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SLACK FUNERAL HOME</b>   |   | ADDRESS<br><b>BOX 268 ELICOTT CITY, MD 21043</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 20 1984</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Johanna Davidson-Randall</b>  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

11-16-64/10X

MARTHA S. HETTCHE

23

4-1-31

6

F

OTV

X

USA

MISS USA

UNIV OF MD CANCER CENTER

DR. HOWARD ELLERSON

MARIO Y. HONTEMEYER

1925-52-6347

NO

SEVERE METABOLIC ACIDOSIS

LIVER FAILURE

MYSTIC BREAST CANCER

X

0 13 11/10

11/10

Case 2 (Gonorrhea)

DR. S. ALEXANDER

11/10

11/10

11/10

11/10

11/10

11/10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |  |  |                                      |  |  |
|--|--|---|--|---|--|--|--------------------------------------|--|--|
| 1- FOR STATE REGISTRAR   |  |   |  |   |  |  |                                      |  |  |
| REG. NO. 8 4 2 9 9 1 5   |  |   |  |   |  |  |                                      |  |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><u>Graham R. Hevell</u>  |  |   |  |   | 2a DATE OF DEATH MONTH DAY YEAR<br><u>November 13, 1984</u>          |  | 2b HOUR<br><u>8:00A</u> <sub>M</sub> |  |  |
| 3 SEX<br><u>M</u>  |  | 4 RACE<br><u>W</u>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><u>Oct. 1, 1905</u>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>79</u> YRS.  |                                      | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Md.</u>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><u>Baltimore City</u> MD.   |                                      |  |  |
| 10 CITY OR TOWN OF DEATH<br><u>Baltimore</u>   |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Maryland General Hospital</u> |  |   |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Engineer</u>  |                                      | 12b KIND OF BUSINESS OR INDUSTRY<br><u>Civil</u>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |  |  |                                      |  |  |
| 13a STATE<br><u>Md.</u>  |  | 13b COUNTY<br><u>Baltimore</u>  |  | 13c CITY OR TOWN<br><u>Baltimore</u>  |  | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                      | 13e STREET ADDRESS / ZIP CODE<br><u>7936 Belridge Rd. 21236</u>  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><u>Charles F. Hevell</u>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><u>Annie G. Graham</u> |  |                                      |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b SOCIAL SECURITY NO.<br><u>162 07 9135</u>   |  | 17 INFORMANT ADDRESS<br><u>Mrs. C. Adele Collidge 7936 Belridge Rd.</u>   |  |  |                                      |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Atherosclerotic cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Urinary tract infection with Sepsis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Bronchopneumonia</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |   |  |  |                                      |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |   |  |   |  |  |                                      |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><u>P.M. 19</u>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |  |                                      |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |                                      |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>October 28</u> , 19 <u>84</u> , to <u>November 13</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>November 13</u> , 19 <u>84</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>(I) (we)</u> (did not) view the body after death. |  |   |  |   |  |  |                                      |  |  |
| 22b. SIGNATURE<br><u>P. Sandhu</u>   |  | DEGREE<br><u>M.D.</u>   |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                      | 22c. DATE SIGNED<br><u>11/13/84</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>P. SANDHU M.D.</u>   |  | 22e. ADDRESS<br><u>c/o Maryland General Hospital</u>  |  |   |  |  |                                      |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>   |  | 23b. DATE<br><u>11/16/84</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Green Mount Cem.</u>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><u>Baltimore, Md.</u>   |                                      |  |  |
| 24 FUNERAL DIRECTOR NAME ADDRESS<br><u>MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd.</u>   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><u>NOV 16 1984</u>  |                                      | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 9 1 6

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |   |  |  |   |
|---|--|--|---|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>WILLIE O. HICKS</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 25 84</b>                |   | 2b. HOUR<br><b>2:00A M</b>   |  |   |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 22 14</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS.<br>IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE, CITY</b> MD.   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VAMC, BALTIMORE MARYLAND 21218</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |   |
| 12b. KIND OF BUSINESS OR INDUSTRY   |  | 13a. STATE<br><b>MD</b>  |   | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |   |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>2706 Bookert Dr. 21225</b>  |   |   |  |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>June Hicks</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Willie Newson</b> |   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>230-03-6971</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Eunice Hicks 2706 Bookert Dr.</b>  |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b>  |  |  |   |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>SEPSIS</b>   |  |  |   |   |  |  |   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |   |   |  |  |   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>BLADDER CANCER</b>   |  |  |   |   |  |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |   |   |  |  |   |
| 19a. DATE OF OPERATION<br><b>11-19-84</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Abdominal abscess</b>   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |
| 22a. I certify that (this hospital) attended the deceased from <b>10/23</b> , 19 <b>84</b> , to <b>11/25</b> , 19 <b>84</b> , that (we) last saw the deceased alive on <b>11/25</b> , 19 <b>84</b> , and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above (X) (we) did (did not) view the body after death. |  |  |   |   |  |  |   |
| 22b. SIGNATURE<br><i>Carla M Ford</i>   |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>11/26/84</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Carla M. Ford, M.D.</b>   |  |  |   | 22e. ADDRESS<br><b>3900 LOCH RAVEN BLVD. BALTIMORE MD. 21218</b>  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11/28/84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Anne Arundel Co. MD</b>                                     |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>   |  |  |   | ADDRESS<br><b>1101 E. North Ave.</b>  |  | 25. DATE REC'D. BY REGISTRAR<br><b>NOV 28 1984</b>   |   |
|   |  |  |   | 26. REGISTRAR'S SIGNATURE<br><i>Carla M Ford</i>  |  |  |   |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

2

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

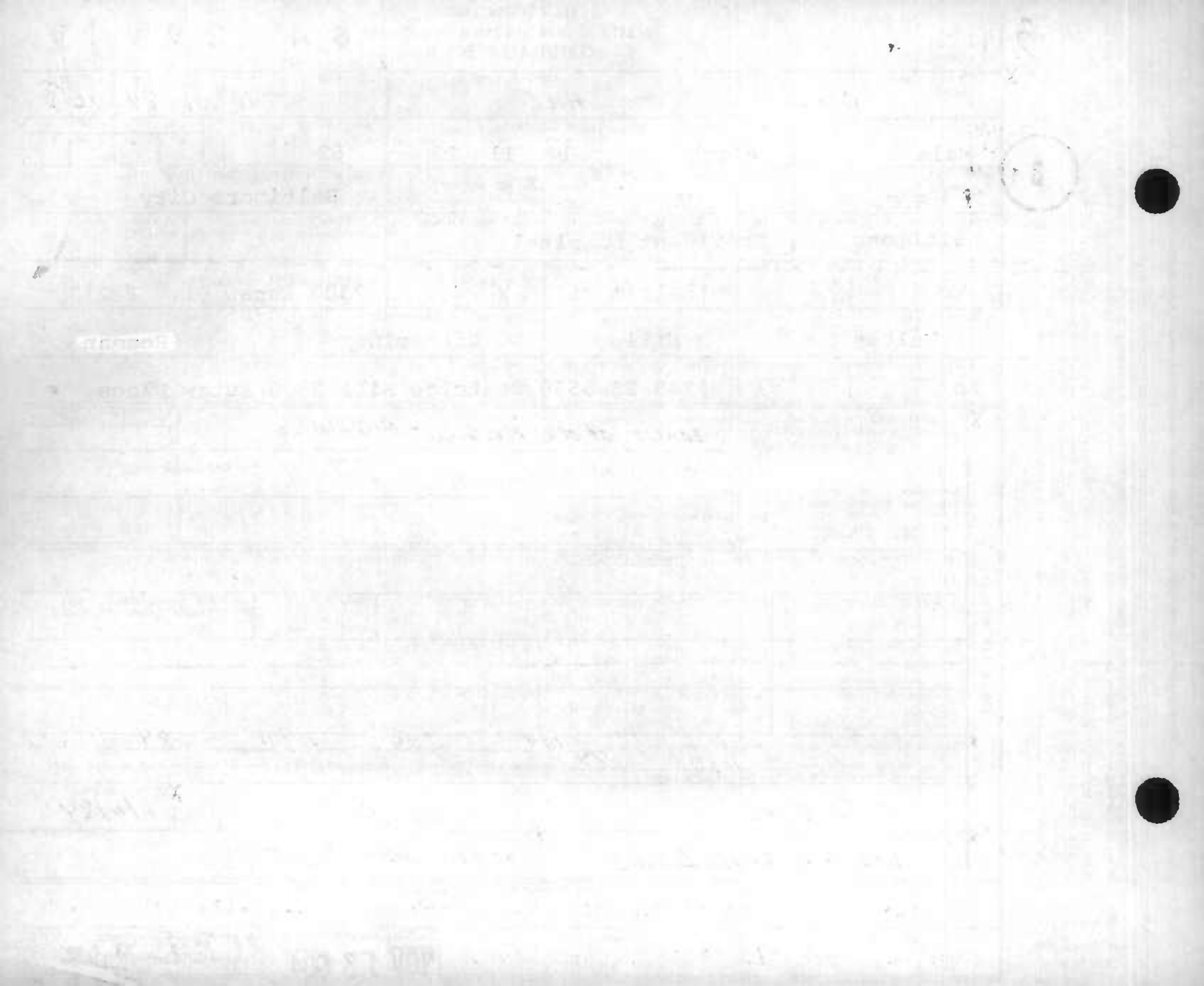
8 4 2 9 9 1 7

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |  |  |  |  |  |  |
|--|--|--|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>OBELL</b>  |  | FIRST<br><b>HILL</b>   |  | MIDDLE  |  | LAST   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 11 84</b>   |  | 2b. HOUR<br><b>12 25 A.M.</b>                |  |
| 3 SEX<br><b>Male</b>   |  | 4 RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 11 22</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S.C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Provident Hospital</b> |  |   |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>2300 Eutaw Pl. 21217</b>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Walter Hill</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Catherine Roman</b>   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>249-28-6559</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Beatrice Hill 2300 Eutaw Place</b>  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cancer of the Prostate - Metastatic</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____   |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>no</b>   |  |  |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21i. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/11/84</b> , 19 <b>84</b> , to <b>11/11</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>11/11</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>H. R. G. M.D.</b>   |  |  |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/11/84</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>WALTER ROYAL M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>2600 Liberty Hgts</b>  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11-15-84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Mem. Park</b>   |  |  |  | 23d. LOCATION<br>CITY OR TOWN<br><b>Randallstown Md.</b> STATE   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H 1101 E. North Ave.</b>   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 13 1984</b>  |  |  |  |  |  |




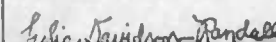


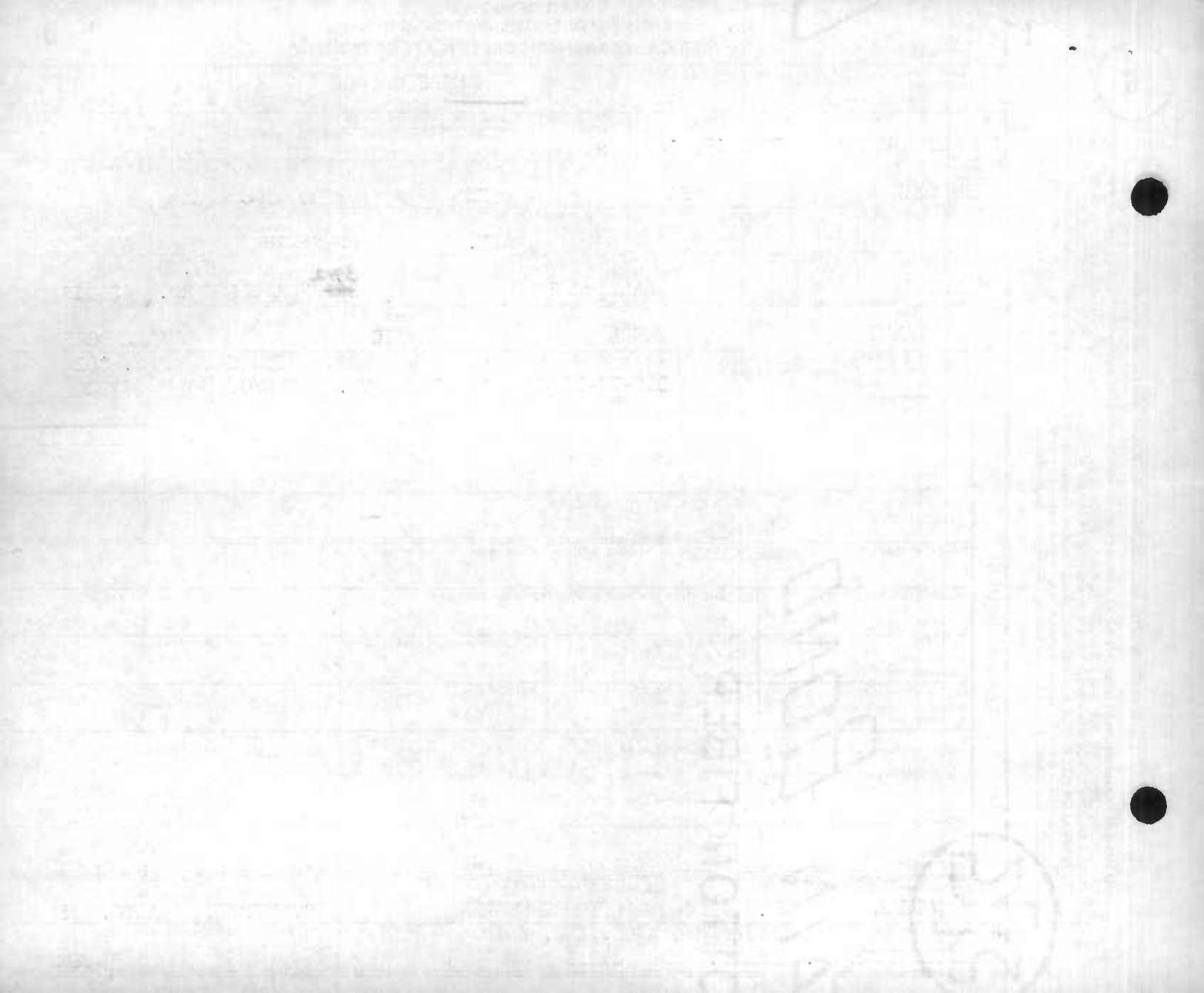
BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                  |  |   |                                |  |  |   |  | REG. NO. 29918                                    |  |
|---|--|------------------|--|---|--------------------------------|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Ruth G. Hirsch   |  |                  |  |   |                                | 2a. DATE KNOWN OF DEATH<br>X MONTH DAY YEAR<br>11/2/84   |  | 2b. HOUR<br>7:40 A M  |  |   |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>JUNE 10, 1890                     |                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br>94 YRS.   |  | 7. IF UNDER 1 YR. MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  | 7c. DATE PRONOUNCED DEAD<br>11/2/84 19            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>NEW YORK   |  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   |                                | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED XX DIVORCED <input type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.          |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3912 Fordleigh Rd., APT. D |   |                                |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME                         |   |  |
| 13a. STATE<br>MARYLAND  |  |                  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br>BALTIMORE |  | 13d. INSIDE CITY LIMITS?<br>YES X NO <input type="checkbox"/>              |   | 13e. ADDRESS<br>3912 APT. D<br>304 FORDLEIGH RD. #21215              |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>ISAAC ENGEL   |  |                  |  |   |                                | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ANNIE MARKENDORF  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>NO   |  |                  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-74-7904D |                                | 17. INFORMANT<br>MRS. EDITH KLEW APT. 802<br>11 SLADE AVE. BALTO., MD 21208  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____     |  |                  |  |   |                                |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH      |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |  |                  |  |   |                                |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                       |                                |  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO X |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19              |                                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)             |                                | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry X, and in my opinion death resulted from: Natural causes, X, Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                  |  |   |                                |  |  |   |  |   |  |
| ACTUAL SIGNATURE<br>   |  |                  |  | TITLE (SPECIFY)<br>M.D. Assistant                                       |                                |  |  | DATE SIGNED<br>11/2/84  |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Gregory R. Kauffman, M.D.   |  |                  |  | ADDRESS<br>111 Penn St.   |                                |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  |                  |  | 23b. DATE<br>NOV. 4, 1984   |                                | 23c. NAME OF CEMETERY OR CREMATORY<br>BALTIMORE HEBREW   |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>REISTERSTOWN BALTO. MD |   |  |
| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC. 6010<br>REISTERSTOWN RD. BALTO., MD 21215   |  |                  |  |   |                                | 25a. DATE REC'D. BY REGISTRAR<br>NOV 7 1984  |  | 25b. REGISTRAR'S SIGNATURE<br> |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director. Page 4 may be retained by the funeral director. Page 5 should be retained by the funeral director. Page 6 should be retained by the funeral director. Page 7 should be retained by the funeral director. Page 8 should be retained by the funeral director. Page 9 should be retained by the funeral director. Page 10 should be retained by the funeral director. Page 11 should be retained by the funeral director. Page 12 should be retained by the funeral director. Page 13 should be retained by the funeral director. Page 14 should be retained by the funeral director. Page 15 should be retained by the funeral director. Page 16 should be retained by the funeral director. Page 17 should be retained by the funeral director. Page 18 should be retained by the funeral director. Page 19 should be retained by the funeral director. Page 20 should be retained by the funeral director. Page 21 should be retained by the funeral director. Page 22 should be retained by the funeral director. Page 23 should be retained by the funeral director. Page 24 should be retained by the funeral director. Page 25 should be retained by the funeral director. Page 26 should be retained by the funeral director. Page 27 should be retained by the funeral director. Page 28 should be retained by the funeral director. Page 29 should be retained by the funeral director. Page 30 should be retained by the funeral director. Page 31 should be retained by the funeral director. Page 32 should be retained by the funeral director. Page 33 should be retained by the funeral director. Page 34 should be retained by the funeral director. Page 35 should be retained by the funeral director. Page 36 should be retained by the funeral director. Page 37 should be retained by the funeral director. Page 38 should be retained by the funeral director. Page 39 should be retained by the funeral director. Page 40 should be retained by the funeral director. Page 41 should be retained by the funeral director. Page 42 should be retained by the funeral director. Page 43 should be retained by the funeral director. Page 44 should be retained by the funeral director. Page 45 should be retained by the funeral director. Page 46 should be retained by the funeral director. Page 47 should be retained by the funeral director. Page 48 should be retained by the funeral director. Page 49 should be retained by the funeral director. Page 50 should be retained by the funeral director. Page 51 should be retained by the funeral director. Page 52 should be retained by the funeral director. Page 53 should be retained by the funeral director. Page 54 should be retained by the funeral director. 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Page 93 should be retained by the funeral director. Page 94 should be retained by the funeral director. Page 95 should be retained by the funeral director. Page 96 should be retained by the funeral director. Page 97 should be retained by the funeral director. Page 98 should be retained by the funeral director. Page 99 should be retained by the funeral director. Page 100 should be retained by the funeral director.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |  |  |
|--|--|--|--|--|--|---|--|--|--|
| 1- FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH  |  |  |  | MONTH DAY YEAR  |  | 2b. HOUR   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | ROBERTA HOBB   |  |  |  | NOVEMBER 20, 1984   |  | 5:31 A.M.  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7. UNDER 1 YEAR  |  |
| Female   |  | Black  |  | 11 16 07   |  | 77 YRS  |  | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |
| N.C.   |  | USA  |  |  |  | BALTIMORE CITY MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| BALTIMORE  |  | JOHNS HOPKINS HOSPITAL   |  |  |  |   |  |  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS / ZIP CODE                                 |  |
| MD   |  |  |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 1418 N. Eden St. 21213   |  |
| 14. FATHER'S NAME  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |  |  |
| George Silvers   |  |  |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS   |  |  |  |
| No   |  | 578-09-7276  |  | Robert Jackson   |  | 1418 N. Eden St.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hepatic Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>(b) <u>hypotension, mesenteric ischemia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>24 hrs</u> |  |  |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>   |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)   |  |   |  |  |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION  |  |   |  |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | STREET   |  | CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11-20-</u> <u>84</u> to <u>11-20</u> <u>84</u> that (I) (we) lost <u>saw the deceased alive on</u> <u>11-20-</u> <u>84</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE   |  |  |  | DEGREE   |  |   |  | 22c. DATE SIGNED   |  |
| <u>Dimitri Merine</u>  |  |  |  |  |  |   |  | <u>11/20/84</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS   |  |   |  |  |  |
| DIMITRI MERINE   |  |  |  | 600 N. Wolfe Street. Balto, Md. 21205  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  | 23e. CITY OR TOWN COUNTY STATE                                 |  |
| Burial   |  | 11/24/84   |  | Eastview Mem. Pk.  |  | Baltimore   |  | MD   |  |
| 24. FUNERAL DIRECTOR   |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |
| Wm. C. March F/H 1101 E. North Ave.  |  |  |  | NOV 23 1984  |  | <u>John Davidson-Randall</u>  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 9 2 0

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>KING HODGE</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 28 84</b> |   |  | 2b. HOUR<br><b>3:51 AM</b>  |  |  |  |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>N</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 14 10</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>                               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hospital of Baltimore</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY                                  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD.</b> |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Balto</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>2503 Violet Ave 21215</b>     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE<br><b>William Hodge</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Fannie Hodge</b>  |  | 16. ADDRESS<br><b>2503 Violet Ave</b>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>223-12-5134</b>   |  | 17. INFORMANT<br><b>Mamie Hodge</b>   |  |   |  |  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**Cardiac arrest**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost.(b) **sepsis**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

**Respiratory failure, ARDS**

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION<br><b>10/6/84</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Small Bowel Obstruction</b> |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)             |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>9/28</b> , 19 <b>84</b> , to <b>11/26</b> , 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>11/26/84</b> , 19 <b>84</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Randal M Sedlak</b> MD   |  |  |  | 22c. DATE SIGNED<br><b>11/28/84</b>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Randal M. Sedlak</b>  |  |  |  | 22e. ADDRESS<br><b>Sinai Hospital of Baltimore</b>                                   |  |   |  |

|   |  |                             |  |   |  |  |  |
|---|--|-----------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial - Cremation</b> |  | 23b. DATE<br><b>12/3/84</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oruid Ridge Cem. Balto. Md</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE         |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leroy O. Sytt</b>                      |  |                             |  | 24b. ADDRESS<br><b>4600 Liberty Hgts Ave</b>                            |  | 24c. DATE REC'D BY REGISTRAR<br><b>NOV 30 1984</b> |  |
|   |  |                             |  | 24d. REGISTRAR'S SIGNATURE<br><b>G. A. Davidson</b>                     |  |  |  |

BP

(A)

KING

HODGE

11 22 11

W

11 11 10

11 11

W

W

William

Thompson

Thompson

NO

W

W

W

W



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |   |   |   |  |  |  |
|--|--|--|--|---|---|---|--|--|--|
| CERTIFICATE OF DEATH   |  |  |  |   |   |   |  |  |  |
| REG. NO. 8 4 2 9 9 2 1   |  |  |  |   |   |   |  |  |  |
| 1. FOR STATE REGISTRAR   |  |  |  |   |   |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  |   | 2a. DATE OF DEATH   |   |  | 2b. HOUR   |  |
| FIRST MIDDLE LAST<br><i>Madelene Hoffman</i>   |  |  |  |   | MONTH DAY YEAR<br><i>November 26, 1984</i>  |   |  | MONTH DAY YEAR<br><i>6:55P</i>   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |   | 6. AGE (IN YEARS LAST BIRTHDAY)                                   |  | 7. IF UNDER 1 YEAR   |  |
| <i>Female</i>  |  | <i>White</i>   |  | MONTH DAY YEAR<br><i>8 12 1906</i>  |   | <i>78</i> YRS.  |  | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH                              |  |  |  |
| <i>Virginia</i>  |  | <i>U.S.A.</i>  |  |   |   | <i>Baltimore City</i> MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)     |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| <i>Baltimore</i>   |  | <i>Maryland General Hospital</i>   |  |   |   | <i>Housewife</i>  |  |  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |   | 13d. STREET ADDRESS / ZIP CODE                                    |  |  |  |
| <i>Maryland</i>  |  | <i>Baltimore</i>   |  | <i>Edgemere</i>   |   | <i>4524 Todd Point Lane 21219</i>                                 |  |  |  |
| 14. FATHER'S NAME (FIRST MIDDLE LAST)  |  |  |  |   | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)  |   |  |  |  |
| <i>Charles Higgs</i>   |  |  |  |   | <i>Cora Hanson</i>  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |   |   |  |  |  |
| <i>No</i>  |  | <i>216-62-1063</i>   |  | <i>7508 New Battle Grove Circle Balto., MD. 21222</i>   |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Pericardial effusion</i><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <i>Atherosclerotic Cardiovascular disease with congestive heart failure.</i><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) |  |  |  |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION   |  |  |  |   |   |   |  |  |  |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |   |   |   |  |  |  |
| 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |   |   |   |  |  |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |   |   |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |   |  |  |  |
| 22a. I certify that <del>the</del> <i>XX</i> (this hospital) attended the deceased from <i>November 26</i> 19 <i>84</i> , to <i>November 26</i> 19 <i>84</i> , that <i>(X)</i> (we) last saw the deceased alive on <i>November 26</i> 19 <i>84</i> , and that in <i>(my)</i> (our) opinion death occurred on the date and hour and from the causes stated above. <i>(X)</i> (we) did <i>(not)</i> view the body after death.   |  |  |  |   |   |   |  |  |  |
| 22b. SIGNATURE <i>Robert E. Roby</i> DEGREE <i>M.D.</i>  |  |  |  |   | 22c. DATE SIGNED <i>11/27/84</i>  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Robert E. Roby, M.D.</i>  |  |  |  |   | 22e. ADDRESS <i>c/o Maryland General Hospital</i>   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>  |  | 23b. DATE <i>11/29/84</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY <i>Gardens Of Faith</i>  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Maryland</i> |  |  |  |
| 24. FUNERAL DIRECTOR NAME <i>Duda-Ruck, Inc.</i> ADDRESS <i>7922 Wise Avenue Dundalk, MD. 21222</i>  |  |  |  |   | 25a. DATE REC'D BY REGISTRAR <i>NOV 30 1984</i> 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> |   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |   |
|--|--|--|--|---|--|--|---|
| 1. FOR STATE REGISTRAR   |  | 70   |  | 84  |  | 29922  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>EARLIE HOGAN</b>  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 1, 1984</b>  |  | 2b. HOUR<br><b>10:00AM</b>   |   |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>B</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 30 09</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Rocky Mt. NC</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE C.ITY</b> MD.   |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>CHURCH HOME HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>LABORER</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>RAILROAD</b>   |   |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>1919 E HOFFMAN ST 21213</b>   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CHARNIE ALSTON</b>  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>705-09-7309</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>RUTH JOHNSON 110 HARVARD ST</b>  |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMA OF STOMACH WITH METASTASIS</b>   |  |  |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |  |   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |   |  |  |   |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |
| 22a. I certify that (I) this hospital attended the deceased from <b>September 29, 84</b> to <b>November 1, 84</b> , that (II) we last saw the deceased alive on <b>November 1, 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |   |
| 22b. SIGNATURE<br><i>W. Impagliatelli</i>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |  | 22c. DATE SIGNED<br><b>11/1/84</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>W. IMPAGLIATELLI, M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>CHURCH HOSPITAL<br/>100 N. BROADWAY, BALTO, MD 21231</b>   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>11/6/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt RUBY</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MD</b>  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Marshall D. Hays</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 5 1984</b>  |  |  |   |
|  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Lina Davidson-Randall</i>  |  |  |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

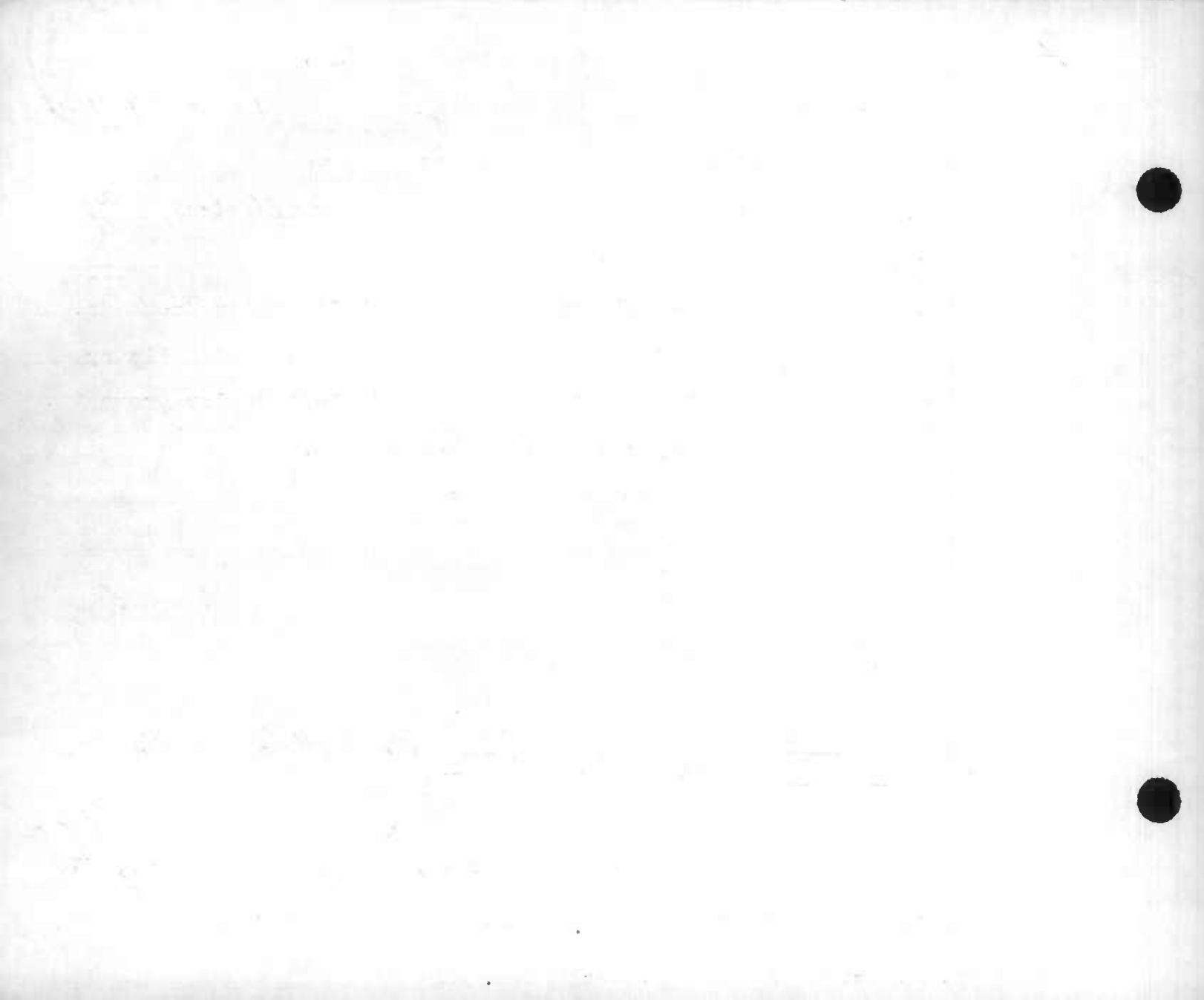
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |   |  |   |  |  | REG. NO.                                       |  |
|---|--|--|--|---|---|--|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JOHN</b> <b>HOLLOWAY</b>   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>06</b> YEAR <b>84</b>                             |  |   | 2b. HOUR<br><b>11:45P</b> M.   |  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>7</b> DAY <b>22</b> YEAR <b>13</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>                                 |  | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Ga.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore city</b> MD.  |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>City</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bon Secour</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 13e. STREET ADDRESS / ZIP CODE<br><b>1422 Poplar Grove St. 21216</b>           |  |  |  |
| 14. FATHER'S NAME<br>FIRST <b></b> MIDDLE <b></b> LAST <b></b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Mary</b> MIDDLE <b>E.</b> LAST <b>Holloway</b>   |   |  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>716-09-0066</b>  |   | 17. INFORMANT<br>ADDRESS <b>Beora Goode 1422 Poplar Grove St.</b>  |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cancer of lung</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>EMPHYSEMA</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |  |  |   |   |  |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                |  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET <b>10/22</b> CITY OR TOWN <b>84</b> COUNTY <b>H/6</b> STATE <b>84</b> |  |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/6</b> 19 <b>84</b> , to <b>11/6</b> 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>11/6</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |   |  |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Kuang-Yen Huang</b>  |  |  | DEGREE<br><b>M.D.</b>  |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  | 22c. DATE SIGNED<br><b>11/7/84</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KUANG-YEN HUANG</b>   |  |  | 22e. ADDRESS<br><b>Bon Secours Hospital</b>                            |   |   |  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>11-10-84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn</b>                                       |  |   | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b></b> STATE <b>Md.</b> |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Wm. C. March F/H 1101 E. North Ave.</b> ADDRESS <b></b>   |  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 8 1984</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>G. Davidson-Randall</b>                       |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed with 7-10 after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-335-1111.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |  |  |  |  |
|--|--|--|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 84   |  | REG. NO. 29924   |  |   |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST  |  | MIDDLE   |  | LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR                               |  | 2b. HOUR a M                                 |  |
| Clarence   |  | E.   |  | Holmes   |  |   |  | November 2, 1984   |  | 7:37   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR MONTHS DAYS                                    |  | IF UNDER 24 HRS. HOURS MIN.                  |  |
| Male   |  | Black  |  | 3 ONTH 4 DAY 27 EAR  |  | 57  |  | YRS.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |  |  |
| N.C.   |  | USA  |  |  |  | Baltimore City MD.  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| Baltimore  |  | 818 E. Preston St.   |  |  |  |   |  |  |  |  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  |  |  |
| MD   |  |  |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 818 E. Preston St. 21202                                       |  |  |  |
| 14. FATHER'S NAME  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |  |  |  |  |
| FIRST MIDDLE LAST  |  |  |  | FIRST MIDDLE LAST  |  |   |  |  |  |  |  |
| Clarence Holmes  |  |  |  | Michael Wise   |  |   |  | Renea Jackson  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  | 16b. SOCIAL SECURITY NO.   |  | ADDRESS   |  |  |  |  |  |
| No   |  |  |  | N/A  |  | 818 E. Preston St.  |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |   |  |  |  |  |  |
| IMMEDIATE CAUSE (a) cardiac arrhythmia   |  |  |  |  |  |   |  |  |  | 5 minutes                                    |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |  |  |   |  |  |  |  |  |
| (b) widely metastatic small cell lung cancer   |  |  |  |  |  |   |  |  |  | ~ 11 months                                  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |  |  |  |  |
| (c)  |  |  |  |  |  |   |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |   |  |  |  |  |  |
|  |  |  |  |  |  |   |  |  |  |  |  |
| MEDICAL CERTIFICATION  |  |  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |  |
|  |  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |  |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |   |  |  |  |  |  |
|  |  | P.M. 19  |  |  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION  |  |   |  |  |  |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |
| 22a. I certify that (I) [this hospital] attended the deceased from MARCH 1, 1984, to NOV 1, 1984, that (I) (we) last saw the deceased alive on NOV 1, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. |  |  |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE   |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | 22c. DATE SIGNED  |  |  |  |  |  |
| Gary Gordon  |  | MD   |  |  |  | 11/2/84   |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS   |  |   |  |  |  |  |  |
| GARY GORDON  |  |  |  | JOHNS HOPKINS HOSPITAL   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  | COUNTY STATE   |  |  |  |
| Burial   |  | 11/6/84  |  | Eastview Mem. Pk.  |  | Baltimore   |  | MD   |  |  |  |
| 24 FUNERAL DIRECTOR NAME   |  |  |  | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR                                       |  | 25b. REGISTRAR'S SIGNATURE                                     |  |  |  |
| Wm. C. March F/H   |  |  |  | 1101 E. North Ave.   |  | NOV 5 1984  |  | John Davidson-Randall  |  |  |  |

BP





WILLIAM COLTON FILE NO. 11



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 9 2 5

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|  |  |   |  |  |   |
|--|--|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>HOLMES, WILLIAM A   |  |   | 7a. DATE OF DEATH<br>MONTH DAY YEAR<br>11/10/84                                  |  | 7b. HOUR<br>7:29 AM   |
| 3. SEX<br>M  | 4. RACE<br>B   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 15 11   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS  | 8. UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>9. UNDER 29 HRS.<br>HOURS MIN.          |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balto. Md.  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balto. City MD.                          |  |   |
| 10. CITY OR TOWN OF DEATH<br>Balto.  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNIV. HOSP. |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Truck Driver | 12b. KIND OF BUSINESS OR INDUSTRY<br>Labor   |   |
| 13a. STATE<br>MD   |  |   | 13b. COUNTY  | 13c. CITY OR TOWN<br>BETHESDA  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOHN A HOLMES  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>CHARLOTTE GORDON                |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.<br>213-70-8496   | 17. INFORMANT<br>Chant Alice Holmes 4317 Marble Hall                             |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardio-pulmonary ARREST<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) unknown<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br>Hepatic mass |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>1 hr.  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/10/84 to 11/10/84, that (I) (we) lost saw the deceased alive on 11/10/84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |  |   |
| 22b. SIGNATURE<br>Marc B. Applestein   |  |   | DEGREE   | 22c. DATE SIGNED<br>11/10/84   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Marc B. Applestein  |  |   | 22e. ADDRESS<br>C/O UNIV. HOSP.  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   | 23b. DATE<br>11-16-84  | 23c. NAME OF CEMETERY OR CREMATORY<br>King Memorial Park  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, MD.                         |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>William C. Brown 1206-08 W. North Ave.   |  |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 16 1984                                     |  |   |
|  |  |   | 25b. REGISTRAR'S SIGNATURE<br>Chia Davidson-Randall                              |  |   |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use at the burial or cremation. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
1. STATE  
REGISTRAR

REG. NO. 4

|   |  |   |   |   |   |
|---|--|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Anthony E. Hood</b>  |  |   | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>22</b> YEAR <b>84</b> 2b. HOUR <b>1:47</b> AM |   |   |
| 3. SEX<br><b>M</b>  | 4. RACE<br><b>B</b>                        | 5. DATE OF BIRTH<br>MONTH <b>10</b> DAY <b>5</b> YEAR <b>49</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>35</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b> |
| 7a. BIRTHPLACE<br>COUNTRY <b>MO</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                         |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore City</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL of BALTO</b>                 |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>bus driver</b> |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. CITY <b>MD</b> 13c. COUNTY <b>BALTO</b> 13d. CITY OR TOWN <b>BALTO</b> |  |   | 13e. STREET ADDRESS / ZIP CODE<br><b>831 N. Rawood Ave 21205</b>                          |   |   |
| 14. FATHER'S NAME<br>FIRST <b>John</b> MIDDLE <b></b> LAST <b>Hood</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Eva</b> MIDDLE <b></b> LAST <b>Rawlings</b>  |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>214-52-8689</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>John &amp; Eva Hood 2605 Maisbury Ct.</b>              |   |

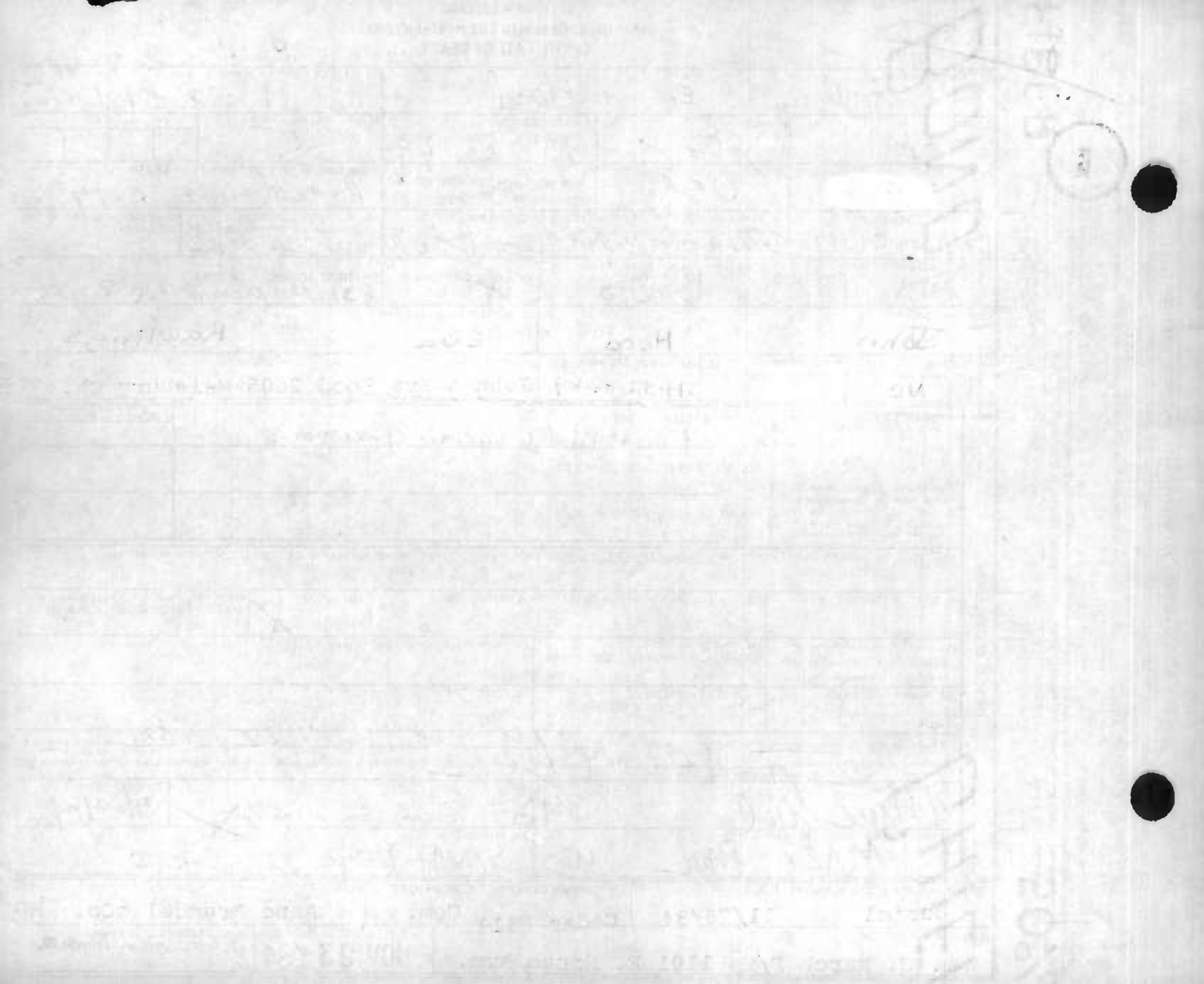
|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumocystis Carinii Pneumonia</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b></b>  |  |   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>  |  |   |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **a**

|   |   |  |   |
|---|---|--|---|
| 19a. DATE OF OPERATION<br><b>11/22/84</b>   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b></b>                       | 20a. AUTOPSY<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b></b> |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b></b> | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b></b>                             |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/22/84</b> to <b>11/22/84</b> , that (I) (we) last saw the deceased alive on <b>11/22/84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |   |  |   |
| 22b. SIGNATURE<br><b>MARC PAUL</b>  | DEGREE<br><b>MD</b>   | 22c. DATE SIGNED<br><b>11/22/84</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARC PAUL</b>   |   | 22e. ADDRESS<br><b>SINAI HOSP. OF BALTO</b>  |   |

|  |                              |  |  |
|--|------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b> | 23b. DATE<br><b>11/26/84</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cem.</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Anne Arundel Co. MD</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>    |                              | 25. DATE REC'D. BY REGISTRAR<br><b>NOV 23 1984</b>           |  |
| ADDRESS<br><b>1101 E. North Ave.</b>                       |                              | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>   |  |

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 9 2 7

REG. NO.

|  |  |   |  |   |              |  |                   |   |             |   |            |                    |
|--|--|---|--|---|--------------|--|-------------------|---|-------------|---|------------|--------------------|
| FOR<br>1. STATE<br>REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br>PHILLIP  | MIDDLE<br>A. | LAST<br>HORSEWOOD  | 2a. DATE OF DEATH |   | MONTH<br>11 | DAY<br>14   | YEAR<br>84 | 2b. HOUR<br>1:37PM |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH  |              | 6. AGE (IN YEARS LAST BIRTHDAY)  |                   | IF UNDER 1 YEAR   |             | IF UNDER 24 HRS   |            |                    |
|  |  |   |  | MONTH<br>9  | DAY<br>8     | YEAR<br>1941   | 43 YRS.           |   | MONTHS      | DAYS  | HOURS      | MIN.               |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Indiana   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |                   |   |             |   |            |                    |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |  |   |              | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>U.S. Army  |                   | 12b. KIND OF BUSINESS OR INDUSTRY   |             |   |            |                    |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland  |  |   |  |   |              | 13b. CITY OR TOWN<br>Millersville  |                   | 13c. STREET ADDRESS / ZIP CODE<br>817 Spingdale Drive 21108   |             |   |            |                    |
| 14. FATHER'S NAME<br>FIRST<br>Russell  |  | MIDDLE<br>D.  |  | LAST<br>Horsewood   |              | 15. MOTHER'S MAIDEN NAME<br>FIRST<br>Alice   |                   | MIDDLE<br>J.  |             | LAST<br>Harris  |            |                    |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>1961-1981  |  | 17. INFORMANT<br>Nancy J. Horsewood   |              | ADDRESS<br>Same as 13c   |                   |   |             |   |            |                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>PULMONARY INSUFFICIENCY</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>ASPIRATION PNEUMONIA</u>   |  |   |  |   |              |  |                   |   |             | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>30 min</u><br><u>6 hours</u><br><u>3 days</u> |            |                    |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).<br><u>MDABID OBESITY</u>  |  |   |  |   |              |  |                   |   |             |   |            |                    |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |              | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |             |   |            |                    |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |              |  |                   |   |             |   |            |                    |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |              |  |                   |   |             |   |            |                    |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/19</u> , 19 <u>84</u> , to <u>11/14</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>11/14</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |              |  |                   |   |             |   |            |                    |
| 22b. SIGNATURE<br><u>Keith Kaufman</u>   |  |   |  |   |              | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                   | 22c. DATE SIGNED<br><u>11/14/84</u>   |             |   |            |                    |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>KEITH KAUFMAN</u>  |  |   |  |   |              | 22e. ADDRESS<br><u>JOHNS HOPKINS HOSPITAL BALI, MD</u>   |                   |   |             |   |            |                    |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>11/19/1984   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arlington National  |              | 23d. LOCATION,<br>CITY OR TOWN<br>Arlington  |                   | COUNTY<br>Virginia  |             | STATE   |            |                    |
| 24. FUNERAL DIRECTOR<br>NAME<br>Duda-Ruck, Inc.<br>7922 Wise Avenue Dundalk, MD. 21222   |  |   |  |   |              | 25a. DATE REC'D. BY REGISTRAR<br>NOV 16 1984   |                   | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |             |   |            |                    |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be mailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked on item 18, check any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 9 2 8

1- STATE REGISTRAR PAULINE M. HOSMER

REG. NO.

|  |  |   |   |  |  |   |  |
|--|--|---|---|--|--|---|--|
| 2a. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Pauline M. Hosmer</b>   |  |   | 2b. DATE OF DEATH MONTH DAY YEAR<br><b>11 - 10 - 84</b> |  |  | 2c. HOUR MIN<br><b>10:21 AM</b>   |  |
| 3. SEX<br><b>F</b><br>Female   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>April 8, 1904</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>80</b>                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                 |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Secretary</b> |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. COUNTY 13d. CITY OR TOWN<br><b>Maryland Baltimore Catonsville</b> |  |   |   | 13e. STREET ADDRESS / ZIP CODE<br><b>309 Lambeth Rd. 21228</b>   |  | 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Horace O. Hosmer</b>                    |  |
| 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Emma K. Blocker</b>   |  |   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  |   |  |
| 16b. SOCIAL SECURITY NO.<br><b>212-05-7175</b>   |  |   |   | 17. INFORMANT ADDRESS<br><b>Virginia E. Hancock 309 Lambeth Rd. 21228</b>  |  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

19c. AUTOPTIST?

19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)

21a. INJURY OCCURRED WHILE ☐ AT WORK NOT WHILE ☐ AT WORK

21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21c. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from **1975** to **Mar 10 1984**, that (I) ~~last~~ saw the deceased alive on **Oct 10 1984**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ~~did~~ (did not) view the body after death.

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

ATTENDING PHYSICIAN

MEDICAL DIRECTOR

STAFF PHYSICIAN

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION CITY OR TOWN

COUNTY

STATE

24. FUNERAL DIRECTOR

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

**Wither Catonsville Funeral Home**  
1630 Edmondson Ave. 21228, Catonsville, Md.

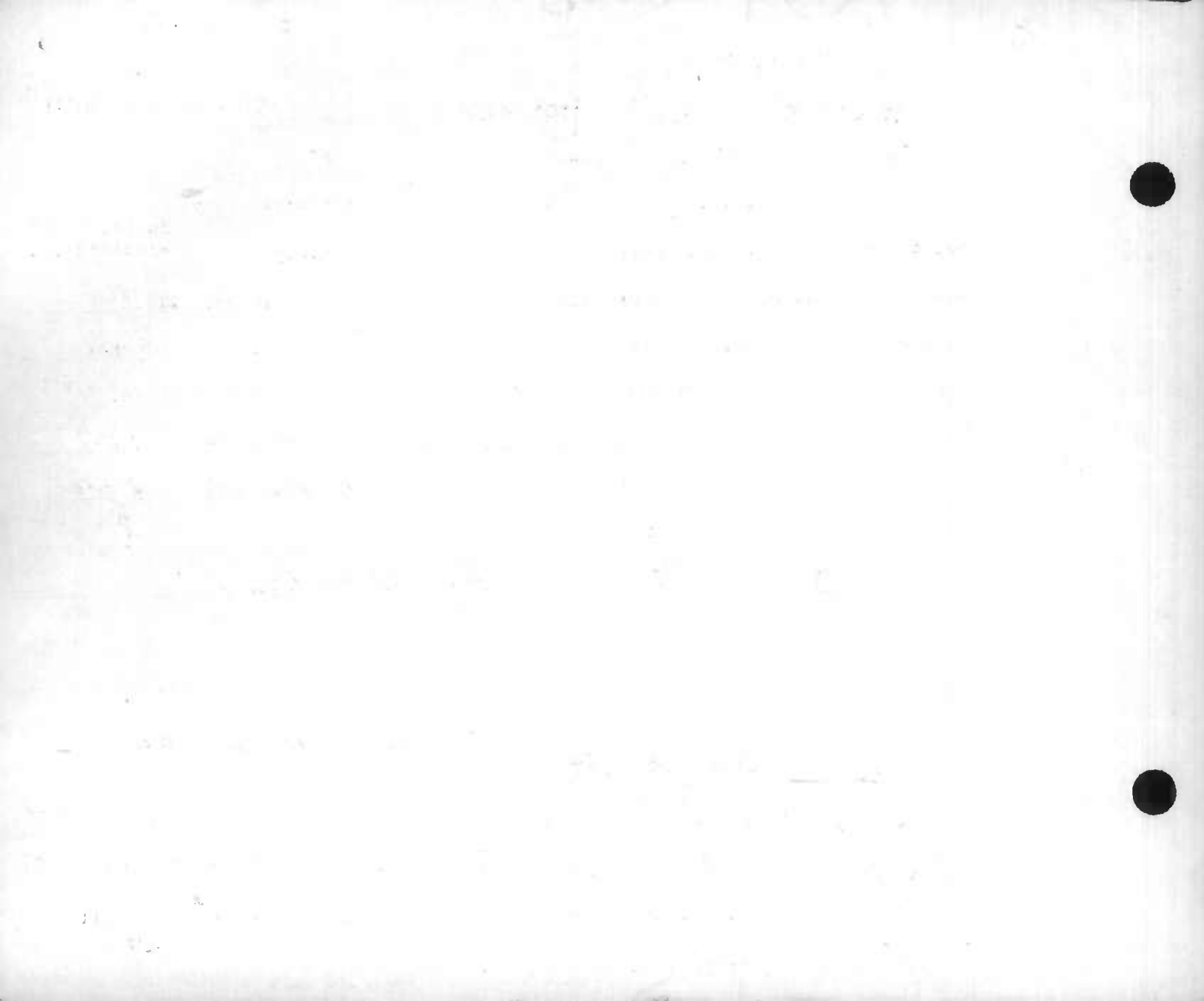
NOV 13 1984

*John Davidson*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |                          |   |  |   |  |  |  |
|--|--|--|--------------------------|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO. 874 29929   |                          |   |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>VIRGINIA M. HOUSER   |  |  |                          |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 04, 1984  |  | 2b. HOUR<br>7:35 P.M.  |  |
| 3 SEX<br>Female  |  | 4. RACE<br>White   |                          | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Dec. 8, 1910  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                       |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Maryland General Hospital |                          |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Secretary                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S. Gov't.   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |                          |   |  |   |  |  |  |
| 13a. STATE<br>MD   |  | 13b. COUNTY  |                          | 13c. CITY OR TOWN<br>Balto.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>4410 Greenway, 21218   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Thomas Alonza Metz   |  |  |                          |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Nannie M. Lee |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  |  | 16b. SOCIAL SECURITY NO. |   | 17. INFORMANT ADDRESS<br>Mason Metz, Same                      |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>End Stage Carcinoma of Pancreas</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |  |                          |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</u>  |  |  |                          |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                          |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                          | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>November 02</u> , 19 <u>84</u> , to <u>November 04</u> , 19 <u>84</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>November 04</u> , 19 <u>84</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did not view the body after death. |  |  |                          |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>S. Ramesh M.D.</u>  |  |  |                          | DEGREE<br>M.D.  |  |   |  | 22c. DATE SIGNED<br>11/5/84.   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>R. Ramesh Sabapathi, M.D.</u>  |  |  |                          | 22e. ADDRESS<br><u>c/o Maryland General Hospital</u>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>11/8/84   |                          | 23c. NAME OF CEMETERY OR CREMATORY<br>Druid Ridge   |  | 23d. LOCATION<br>(CITY OR TOWN) COUNTY STATE<br>Pikesville, MD                                  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <u>Henry W. Jenkins &amp; Sons Co.</u><br>ADDRESS <u>4905 York Road Balto., MD 21212</u>  |  |  |                          |   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 7 1984   |  | 25b. REGISTRAR'S SIGNATURE<br><u>John Davidson</u>   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |  |  |  |   |  | 8 4 2 9 9 3 0  |  |  |  |
|---|--|---|--|---|--|--|--|---|--|--|--|--|--|
| 1- FOR STATE REGISTRAR  |  |   |  |   |  |  |  |   |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>George HENRY Howard   |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>11-20-84   |  |   |  | 2b. HOUR<br>M  |  |  |  |
| 3 SEX<br>M  |  | 4. RACE<br>NEGRO  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>7 31 03  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS<br>HOURS MIN   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO. CITY MD.  |  |   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2559 Cecil Ave |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>LONGSHOREMAN  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |  |
| 13a. STATE<br>Md  |  |   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>BALTO   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>2559 Cecil Ave 71218  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>DANIEL HOWARD  |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>LEVENIA HARDY  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  |   |  | 16b. SOCIAL SECURITY NO.<br>RIS-1L-4190   |  | 17. INFORMANT ADDRESS<br>CLARA HOWARD 2559 Cecil Ave   |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarct</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Arteriosclerosis M70</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |  |  |
| 22a. I certify that (I) (his hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>M70   |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>M Tacer  |  |   |  |   |  | 22e. ADDRESS<br>1576 M Smith Blvd  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (IF APPLICABLE)<br>BURIAL   |  |   |  | 23b. DATE<br>11/23/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>BALTO  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. CITY MD                                    |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>LOCKS FUNERAL HOME   |  |   |  |   |  | ADDRESS<br>1304 N. Central   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 23 1984  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |

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2025 COTTON FIBER

MAILED

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 9 3 2

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |                            |   |  |  |  |
|---|--|---|---|---|----------------------------|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST <u>MARTIN</u> MIDDLE <u>JAMES</u> LAST <u>HUGHES</u><br><u>MARTIN J HUGHES</u>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><u>11/22/84</u> |   | 2b. HOUR<br><u>5:30 AM</u> |   |  |  |  |
| 3. SEX<br><u>MALE M</u>   |  | 4. RACE<br><u>WHITE W</u>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><u>03 26 1932</u>   |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>52</u> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>MARYLAND</u>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Baltimore City</u> MD.                               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><u>BALTIMORE</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>UNIVERSITY OF MARYLAND HOSP</u> |   |   |                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>BUYER/CLERK</u>          |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>Proctor/Gamble</u>   |  |
| 13a. STATE<br><u>MD</u>   |  | 13b. COUNTY<br><u>A.A.</u>  |   | 13c. CITY OR TOWN<br><u>Glen Burnie</u>   |                            | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><u>403 GLENMONT AVE</u> <u>21061</u>   |  |
| 14. FATHER'S NAME<br>FIRST <u>THOMAS</u> MIDDLE <u>J.</u> LAST <u>HUGHES</u>  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <u>ELIZABETH</u> MIDDLE <u>H.</u> LAST <u>ROBERTS</u>   |                            |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>Yes Army</u>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><u>11/16754</u>  |   | 17. INFORMANT<br><u>Mrs. Norma E. Hughes (Wife) Sames as 13</u>   |                            |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>END STAGE CANCER OF THE STOMACH</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |   |                            |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a   |  |   |   |   |                            |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |                            | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                            |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                            |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/21</u> 19 <u>84</u> to <u>11/22</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>11/22</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (they) did not view the body after death.                                    |  |   |   |   |                            |   |  |  |  |
| 22b. SIGNATURE<br><u>T. Nguyen MD</u>   |  | DEGREE  |   |   |                            | 22c. DATE SIGNED<br><u>11/22/84</u>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>THUY VI NGUYEN</u>  |  | 22e. ADDRESS<br><u>UNIV. OF MARYLAND HOSPITAL</u>   |   |   |                            | DEPARTMENT OF INTERNAL MEDICINE   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>  |  | 23b. DATE<br><u>Nov. 26, 1984</u>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Cedar Hill</u>   |                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Brooklyn A.A. MD.</u>                          |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <u>Singleton Funeral Home</u> ADDRESS <u>Glen Burnie, Md</u>   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><u>NOV 27 1984</u>   |                            | 25b. REGISTRAR'S SIGNATURE<br><u>John Davidson-Randall</u>                                      |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified by the State Dept. of Health and Mental Hygiene.

3

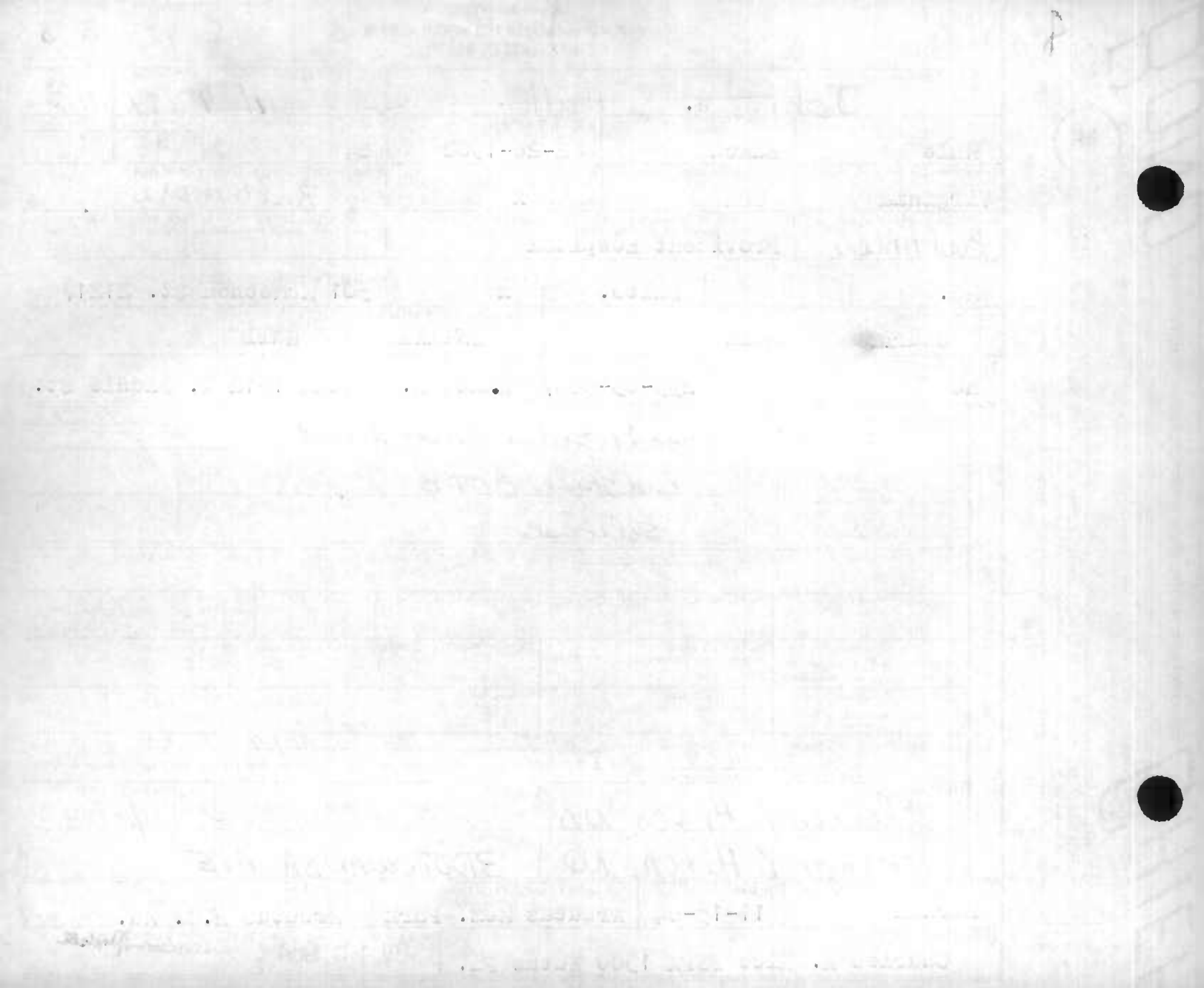
AGG S. VON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |   |   |   |  |  |   |   |
|---|--|---|---|---|---|--|--|---|---|
| 1. FOR STATE REGISTRAR  |  |   |   |   | REG. NO. 8 4 2 9 9 3 3  |  |  |   |   |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>John W. Hull</b>  |  |   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>10/ 9 84</b>                           |  |  | 2b. HOUR<br><b>11<sup>55</sup> P M</b>                          |   |
| 3 SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b>   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>2-26-1900</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.      |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b> MD.                                 |  |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Provident Hospital</b> |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY                               |   |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><b>Balto.</b>  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>301 McMechen St. 21217</b> |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Charlie Hull</b>  |  |   |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Lizzie Hull</b>              |  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>235-03-9667</b>  |   | 17. INFORMANT ADDRESS<br><b>Alice H. Catlin 1612 E. Biddle St.</b>  |   |  |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>End stage COPD</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Silicosis</b> |  |   |   |   |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.   |  |   |   |   |   |  |  |   |   |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |   |   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |  |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/9</b> 19 <b>84</b> to <b>11/9</b> 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>11/9</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                            |  |   |   |   |   |  |  |   |   |
| 22b. SIGNATURE<br><b>Eleanor Y. Hixon MD</b>  |  |   |   |   | DEGREE<br><b>MD</b>   |  |  | 22c. DATE SIGNED<br><b>11/10/84</b>                             |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Eleanor Y. Hixon MD</b>   |  |   |   |   | 22e. ADDRESS<br><b>3100 TOWANDA AVE</b>                                       |  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>  |  |   | 23b. DATE<br><b>11-15-84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Park</b>                |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Arbutus H.C. Md.</b>     |   |   |
| 24. FUNERAL DIRECTOR NAME<br><b>Charles A. Rice FSPA</b>  |  |   |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 15 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>John Davidson</i>              |   |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

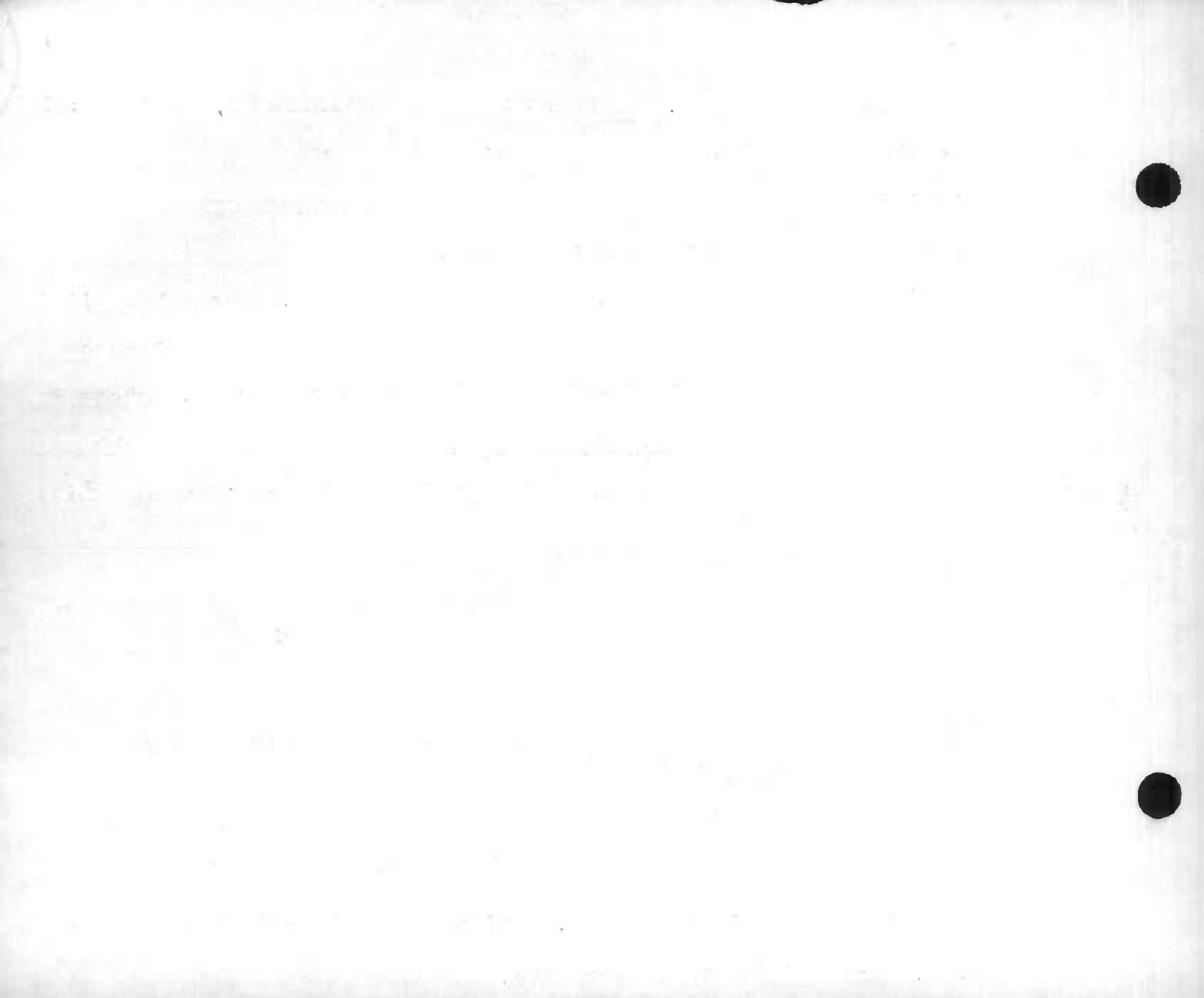
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 9 3 4

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |  |  |   |  |   |  |
|---|--|---|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MARY MIDDLE H. LAST HUMBLE   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>NOVEMBER 19, 1984                  |   |  | 2b. HOUR<br>10:03 <sup>PM</sup>  |   |  |   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 15 20   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>64 YRS.   |   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>JOHNS HOPKINS HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| 13a. STATE<br>Md.   |  |   | 13b. COUNTY  |   | 13c. CITY OR TOWN<br>Balto.  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 14. FATHER'S NAME<br>FIRST Fred MIDDLE LAST Cousin  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST Sarah MIDDLE LAST Sparrow            |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |   |  | 16b. SOCIAL SECURITY NO.<br>214-22-1599 |  |
| 17. INFORMANT<br>Christine Alston   |  |   | ADDRESS<br>906 N. Duncan St.   |   |  | 17a. STREET ADDRESS / ZIP CODE<br>906 N. Duncan St. 21205  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Hypertension<br>DUE TO, OR AS A CONSEQUENCE OF (b) Massive intra ventricular hemorrhage 3 days<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>30 min |  |   |  |   |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11c  |  |   |  |   |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/19 10:03 PM 84, to 11/19 84, that (I) (we) lost above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |   |  |   |  |
| 22b. SIGNATURE<br>Edward Kasper   |  |   | DEGREE<br>MD   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>11/19/84   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>EDWARD KASPER  |  |   | 22e. ADDRESS<br>Johns Hopkins Hosp.                                    |   |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |   | 23b. DATE<br>11-26-84  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Md, National                             |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Laurel, Md.                                       |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Wm. C. March F/H 1101 E. North Ave.   |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 21 1984                                   |  | 25b. REGISTRAR'S SIGNATURE<br>Davidson-Randall  |  |   |  |





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 9 3 5

REG. NO.

1. FOR  
STATE  
REGISTRAR

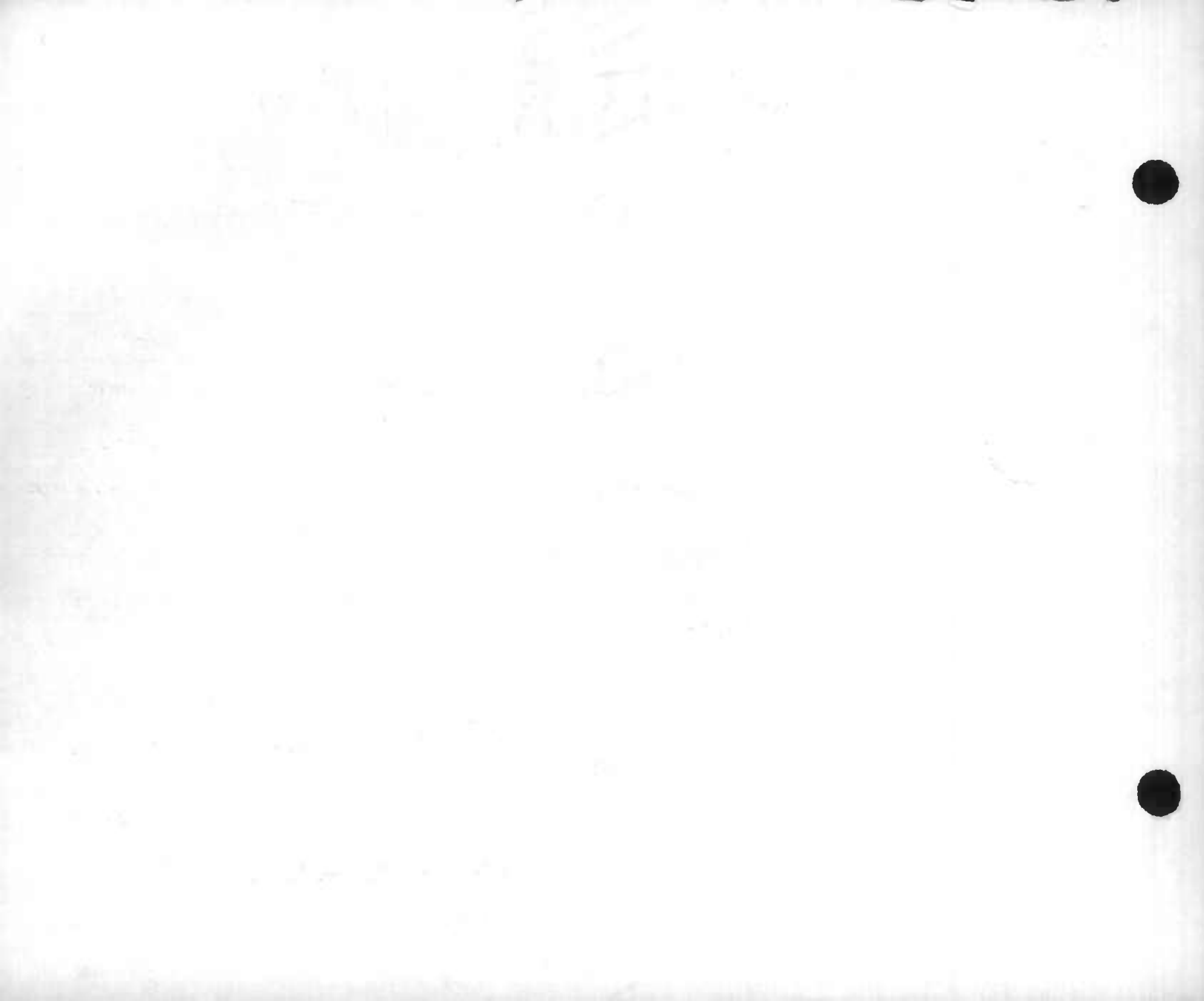
|   |  |  |  |   |  |  |
|---|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>CLARENCE (CLARENCE, HUNT) T. HUNT  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11/2/84                 |   | 2b. HOUR<br>8:18 PM  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Black   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 14 29   |  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>55   |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE MD.  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE CITY   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                            |  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |   |  |  |
| 13a. STATE<br>MD  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  |  |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE<br>2739 Fenwick Ave. 21218  |  |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>- - -   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Isabelle Ward |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) No   |  | 16b. SOCIAL SECURITY NO.<br>218-26-0213  |  | 17. INFORMANT<br>ADDRESS<br>Ethel M. Hunt 2739 Fenwick Avenue                               |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>HEPATORENAL SYNDROME</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>CIRRHOSIS</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>HYPOTENSION</u> |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 WEEK</u><br><u>MANY YEARS PDA</u> |  |
| 19a. DATE OF OPERATION<br><u>NA</u>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>NA</u>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                   |  |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><u>NA</u> |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><u>1a</u>  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>10/24/84</u> to <u>11/2</u> 19 <u>84</u> , that (1) (we) lost saw the deceased alive on <u>8:47 PM 11/2 19 84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |
| 22b. SIGNATURE<br><u>Scott Cerish</u>   |  | DEGREE<br><u>MD</u>  |  | 22c. DATE SIGNED<br><u>11/2/84</u>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Scott Cerish   |  | 22e. ADDRESS<br>UNION MEMORIAL HOSPITAL  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>11/8/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Eastview Mem. Pk.                                     |  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore MD  |  |  |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H  |  | ADDRESS<br>1101 E. North Ave.  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 5 1984   |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Randell</u>   |  |  |  |   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

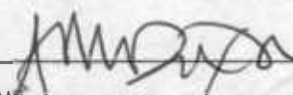
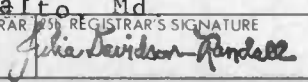
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                         |   |  |   |   |   |  |   |  | REG. NO. 29936  |  |
|--|-------------------------|---|--|---|---|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>DWAYNE L. HUNT</b>  |                         |   |  |   |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH <b>11</b> DAY <b>10</b> YEAR <b>1984</b> |  | 2b. HOUR <b>M</b>   |  |   |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Black</b> | 5. DATE OF BIRTH<br>MONTH <b>8</b> DAY <b>20</b> YEAR <b>65</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>19</b> YRS.                            | IF UNDER 1 YR.<br>MONTHS <b></b> DAYS <b></b>   | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b>  | 2c. DATE PRONOUNCED DEAD<br><b>11 10 1984</b>   |  | 2d. HOUR <b>7:45 a M</b>  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto. Md.</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>7200 blk. Sauers Ct.</b> |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |
| 13a. STATE<br><b>Md.</b>   |                         | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                    |  | 13e. STREET ADDRESS<br><b>7214 Sauers Ct. 21237</b>                                 |  |   |  |
| 14. FATHER'S NAME<br>FIRST <b>Robert</b> MIDDLE <b>E.</b> LAST <b>Hunt</b>   |                         |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Linda</b> MIDDLE <b></b> LAST <b>Jackson</b>   |   |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |                         | (IF YES, GIVE WAR OR DATES)   |  | 16b. SOCIAL SECURITY NO.<br><b>216-92-1212</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Linda Hunt 7214 Sauers Ct.</b>   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple gunshot wounds (handgun)</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost:<br>(b) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF  |                         |   |  |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I   |                         |   |  |   |   |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |                         |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |   |   |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>7:30 11-10-1984</b>    |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br><b>Subject shot.</b> |   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |                         |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>street</b> |   | 21f. LOCATION<br>STREET<br><b>7200 Blk. Sauers Ct., Balto. City</b>                                   |   | CITY OR TOWN<br><b>Balto. City</b>                 |   | STATE<br><b>Md.</b>                          |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |   |  |   |   |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br>  |                         |   | TITLE (SPECIFY)<br>M.D. <b>Assistant</b> MEDICAL EXAMINER                    |   |   |   |  | DATE SIGNED <b>11-10-84</b>   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Ann M. Dixon, M.D.</b>   |                         |   | ADDRESS<br><b>111 Penn St., Balto., Md. 21201</b>                            |   |   |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |                         |   | 23b. DATE<br><b>11-14-84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Balto. Cem.</b>  |   | 23d. LOCATION<br>CITY OR TOWN<br><b>Balto. Md.</b> |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>  |                         |   | ADDRESS<br><b>1101 East North Ave.</b>                                       |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 13 1984</b>   |   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br> |  |



LIBRARY

AND



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 9 3 7

REG. NO.

|   |         |  |        |  |          |   |          |       |
|---|---------|--|--------|--|----------|---|----------|-------|
| 1. FOR<br>STATE<br>REGISTRAR  |         | 2a. DATE OF DEATH  |        | MONTH  | DAY      | YEAR  | 2b. HOUR |       |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         | FIRST  | MIDDLE | LAST   | 11       |   |          | 17 84 |
| Dorothy M. Hurt   |         |  |        |  | 240 A.M. |   |          |       |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH   |        | 6. AGE (IN YEARS LAST BIRTHDAY)  |          | 7. IF UNDER 1 YEAR  |          |       |
| Female  | Black   | MONTH  | DAY    | YEAR   | 52       | YRS.  |          |       |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |          | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |          |       |
| GA  |         | USA  |        |  |          | Baltimore City  |          |       |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |        | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |          | 12b. KIND OF BUSINESS OR INDUSTRY                                   |          |       |
| Baltimore   |         | Mercy Hospital   |        |  |          |   |          |       |
| 13a. STATE  |         | 13b. COUNTY  |        | 13c. CITY OR TOWN  |          | 13d. INSIDE CITY LIMITS?  |          |       |
| MD  |         |  |        | Baltimore  |          | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |          |       |
| 14. FATHER'S NAME   |         | 15. MOTHER'S MAIDEN NAME   |        | 13e. STREET ADDRESS  |          |   |          |       |
| FIRST MIDDLE LAST   |         | FIRST MIDDLE LAST  |        | 2320 Whittier Ave. 21217   |          |   |          |       |
| Edmond  |         | Hurt   |        | Elnora   |          | Giles   |          |       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |         | 16b. SOCIAL SECURITY NO.   |        | 17. INFORMANT  |          | ADDRESS   |          |       |
| No  |         | N/A  |        | Alma Wiley   |          | 2719 W. North Avenue  |          |       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         |  |        |  |          |   |          |       |
| PART I. DEATH WAS CAUSED BY:  |         |  |        |  |          |   |          |       |
| IMMEDIATE CAUSE (a) <u>Pneumonia</u>  |         |  |        |  |          |   |          |       |
| DUE TO, OR AS A CONSEQUENCE OF:   |         |  |        |  |          |   |          |       |
| (b) <u>UGI Bleeding</u>   |         |  |        |  |          |   |          |       |
| DUE TO, OR AS A CONSEQUENCE OF:   |         |  |        |  |          |   |          |       |
| (c) <u>Scleroderma</u>  |         |  |        |  |          |   |          |       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |         |  |        |  |          |   |          |       |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |        | 20a. AUTOPSY?  |          | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |          |       |
|   |         |  |        | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |          | YES <input type="checkbox"/> NO <input type="checkbox"/>            |          |       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |         | 21b. TIME OF INJURY  |        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |          |   |          |       |
|   |         | HOUR A.M. MONTH DAY YEAR   |        |  |          |   |          |       |
|   |         | P.M. 19  |        |  |          |   |          |       |
| 21d. INJURY OCCURRED  |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |        | 21f. LOCATION  |          | CITY OR TOWN COUNTY STATE   |          |       |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK   |         |  |        | STREET   |          |   |          |       |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |         |  |        |  |          |   |          |       |
| 22b. SIGNATURE  |         | DEGREE   |        | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |          | 22c. DATE SIGNED  |          |       |
|   |         | MD   |        |  |          | 11/11/84  |          |       |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |         | 22e. ADDRESS   |        |  |          |   |          |       |
| G. Pokrywka   |         |  |        |  |          |   |          |       |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |         | 23b. DATE  |        | 23c. NAME OF CEMETERY OR CREMATORY   |          | 23d. LOCATION   |          |       |
| Burial  |         | 11/21/84   |        | Baltimore Cem.   |          | Baltimore MD  |          |       |
| 24. FUNERAL DIRECTOR  |         | 25a. DATE REC'D. BY REGISTRAR  |        | 25b. REGISTRAR'S SIGNATURE   |          |   |          |       |
| NAME ADDRESS  |         | NOV 19 1984  |        | Julia Davidson-Randall   |          |   |          |       |
| Wm. C. March F/H  |         | 1101 E. North Ave.   |        |  |          |   |          |       |



CHIEF MAN

20% COTTON

11-2 B-2-11  
2-11-11

11-2 B-2-11  
2-11-11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

84 REG. NO. 29938

|   |  |   |   |   |  |
|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>EMANUEL A. HURWITZ</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 22 84</b>  |   | 2b. HOUR<br><b>503 AM</b>  |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 28 98</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY, MD</b>                                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>PROPRIETOR</b>           | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>TRUCKING</b>  |  |
| 13a. STATE<br><b>MD</b>   | 13b. COUNTY  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>7111 Park Heights Ave Apt 601 21215</b>                          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>SIMON HURWITZ</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>FANNIE UNKNOWN</b>  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>216-32-9344</b>  |   | 17. INFORMANT<br><b>MRS. SARAH B. HURWITZ APT. 601</b><br><b>7111 PARK HTS. AVE. BALTO., MD 21215</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>45 minutes</b> |  |   |   |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |   |   |   |  |
| 19a. DATE OF OPERATION<br><b>11/20/84</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Abdominal Aortic Aneurysm</b>  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                        |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/11</b> , 19 <b>84</b> , to <b>11/22</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>11/22</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.   |  |   |   |   |  |
| 22b. SIGNATURE<br><b>Randal M Sedlak</b>  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |   |   | 22c. DATE SIGNED<br><b>11/22/84</b>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Randal M. Sedlak</b>  |  | 22e. ADDRESS<br><b>SINAI HOSPITAL OF BALTIMORE</b>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>  |  | 23b. DATE<br><b>NOV. 23, 1984</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE HEBREW</b>                                   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>REISTERSTOWN BALTO. MD</b>  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b><br>ADDRESS<br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 28 1984</b>   |   |  |
|   |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson Rindell</b>                                     |   |  |

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 4 2 9 9 3 9  |  |   |   |
|---|--|---|--|--|--|---|---|
| 1 - FOR STATE REGISTRAR   |  |   |  | REG. NO.   |  |   |   |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>SAMUEL HUTTON</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>OCTOBER 29, 1984</b>  |  | 2b. HOUR<br><b>3:16 P M</b>   |   |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>BLACK</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>10/23/1984</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS<br><b>6</b>  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD</b>  |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |   |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>THE THERESA C. HUTTON</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>THE THERESA C. HUTTON</b>   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS<br><b>THE THERESA C. HUTTON ABOVE</b>  |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Probable myocardial infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pulmonary insufficiency</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Group B Streptococcal Sepsis</u>  |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 hour</u><br><u>3 days</u><br><u>6 days</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>Renal failure</u>  |  |   |  |  |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)   |  |   |   |
| 21d. INJURY OCCURRED AT WORK <input type="checkbox"/> WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/23</u> , 19 <u>84</u> , to <u>10/29</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>10/29</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |   |
| 22b. SIGNATURE<br><u>Reid Thompson</u>  |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | 22c. DATE SIGNED<br><u>10/29/84</u>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Reid Thompson</u>   |  | 22e. ADDRESS<br><u>600 N. WOLFE ST. BALTO, MD 21205</u>   |  | 22f. LOCATION<br><u>Johns Hopkins Hospital, Baltimore, MD</u>  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>CREMATION</b>   |  | 23b. DATE<br><b>10/31/1984</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>JHH</b>   |  | 23d. LOCATION<br><b>BALTIMORE, MD. 21205</b>  |   |
| 24. FUNERAL DIRECTOR NAME<br><b>BP</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 20 1984</b>  |  |   |   |
| 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |   |  |  |  |   |   |



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

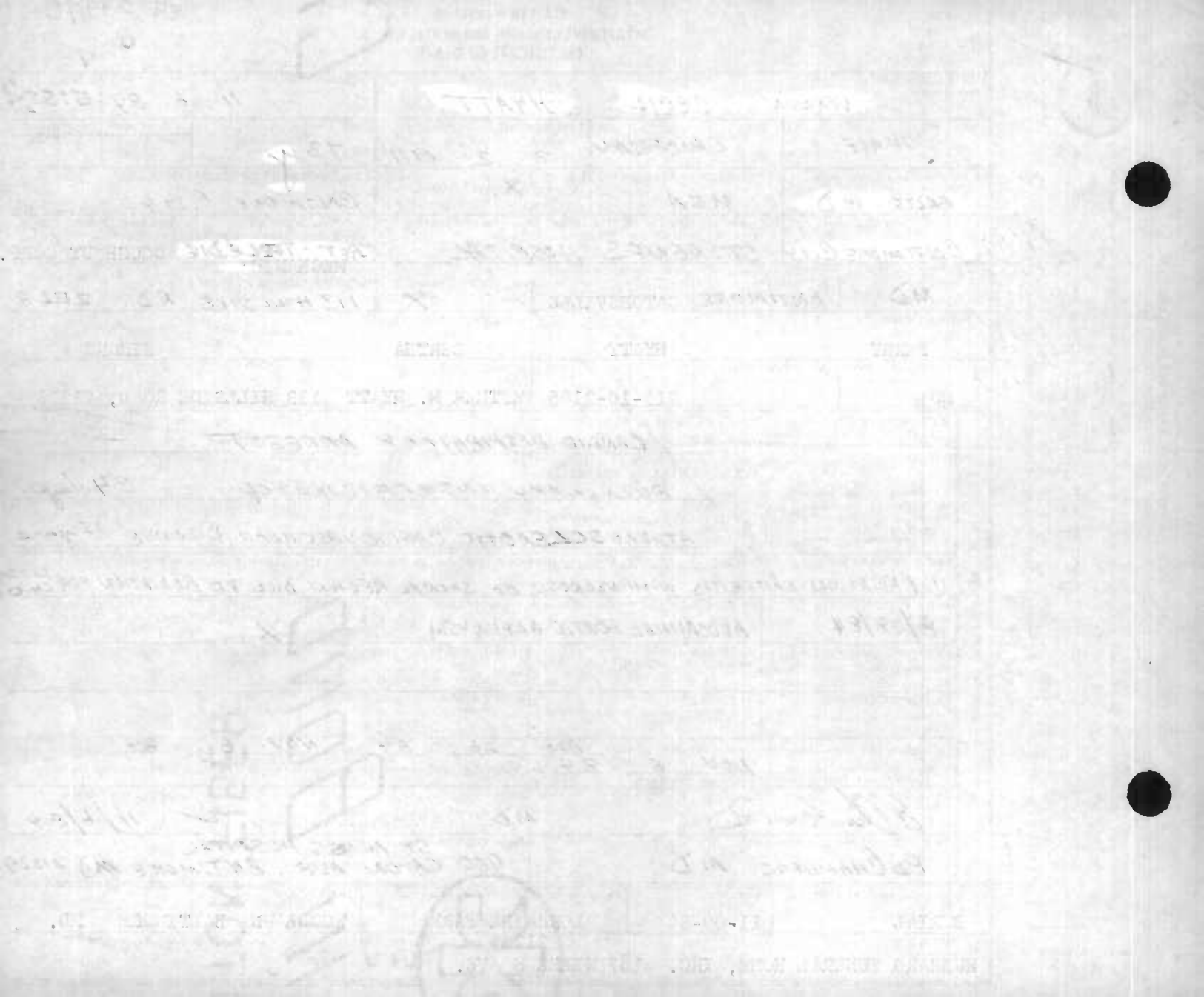
|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>VERNON CECIL HYATT</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11 6 84</b> |   |  | 2b. HOUR<br><b>5:55 AM</b>   |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>CAUCASIAN</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>3 2 1911</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>TOOL &amp; DIE MECHANIC</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>DOUGHNUT CORP.</b>   |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>VENTIMORE</b>  |  | 13c. CITY OR TOWN<br><b>CATONSVILLE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>PERRY</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>BERTHA SIMONS</b>   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  |  |  |
| 17. SOCIAL SECURITY NO.<br><b>215-10-2105</b>   |  | 18. INFORMANT ADDRESS<br><b>ESTHER M. HYATT 113 HILLSIDE ROAD, 21228</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>PULMONARY INSUFFICIENCY</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b><br>Approximate interval between onset and death: <b>34 days</b><br><b>15 years</b> |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:<br><b>(1) RADIATION ENTERITIS WITH NECROSIS OF SACRAL REGION DUE TO RADIATION FOR PRESTON CANCER</b>  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>8/28/84</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>ABDOMINAL AORTIC ANEURYSM</b>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>AUG. 26, 1984</b> to <b>NOV. 6, 1984</b> , that (I) (we) last saw the deceased alive on <b>NOV. 6, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d) (did not) view the body after death.  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>E. Chambers</b>  |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>11/6/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ED CHAMBERS MD</b>  |  | 22e. ADDRESS<br><b>ST AGNES HOSPITAL<br/>900 CATON AVE., BALTIMORE MD 21229</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>11-09-84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LORRAINE PARK</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>WOODLAWN BALTIMORE MD.</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HUBBARD FUNERAL HOME, INC.</b>   |  | ADDRESS<br><b>4107 WILKENS AVE.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 9 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH821 29941  
REG. NO.

|  |  |  |  |  |   |
|--|--|--|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>MARY A IMES</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11 18 84</b>                              |  | 2b. HOUR<br><b>06:45 AM</b>                   |
| 3 SEX<br><b>FEMALE</b>   | 4 RACE<br><b>BLACK</b>   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>06 01 1906</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS HOURS MIN.<br><b>78</b>                      |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>                            |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIVERSITY OF MD HOSPITAL</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>DOMESTIC</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>—</b> |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE<br><b>MD</b> |  | 13b. COUNTY<br><b>—</b>  | 13c. CITY OR TOWN<br><b>BALT.</b>  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>GEORGE — —</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>LULA — —</b>  |  | 16. STREET ADDRESS / ZIP CODE<br><b>701 W MULBERRY 21201</b>                                 |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>           |  | 16b. SOCIAL SECURITY NO.<br><b>217-16-0453</b>   |  | 17. INFORMANT<br><b>SHARLEY IMES 21201</b>   |   |

|   |  |  |
|---|--|--|
| 11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a). <b>CARDIAC ARREST</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 years</b> |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b). <b>MYOCARDIAL INFARCTION</b>   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c). <b>—</b>   |  |  |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

|  |  |  |  |   |   |
|--|--|--|--|---|---|
| 19a. DATE OF OPERATION<br><b>—</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>RENAL FAILURE</b> |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)     |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)      |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Nov. 14</b> , 19 <b>84</b> , to <b>Nov. 18</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>Nov 18</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |
| 22b. SIGNATURE<br><b>Joyce B. Harp</b>   |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>11/18/84</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOYCE B. HARP MD</b>   |  | 22e. ADDRESS<br><b>22 S. GREENE ST - UNIV. HOSP BALTIMORE MD</b>         |  |   |   |

|  |                              |  |  |
|--|------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (IF BY)<br><b>BURIAL</b> | 23b. DATE<br><b>11-23-84</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Park</b> | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTO. Co. Md.</b> |
| 24. FUNERAL DIRECTOR NAME<br><b>Joseph L. Russ</b>       |                              | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 21 1984</b>            |  |
| ADDRESS<br><b>2222 W North Ave.</b>                      |                              | REGISTRAR'S SIGNATURE<br><b>J. Davidson</b>                    |  |

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

84 29942

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |   |  |   |  |   |   |                                   |   |  |
|---|--|---|--|---|--|---|---|-----------------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Carrie P Jackson   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 8 84                         |   |  | 2b. HOUR<br>7 15 P.M.   |   |                                   |   |  |
| 3. SEX<br>F   |  | 4. RACE<br>B  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 1 36  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>48 YRS.                                    |   |                                   |   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Baltimore, Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                    |   |                                   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>U. Maryland Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(LIST WORK FOR WHICH MOST TIME SPENT)<br>Sales Clerk |   | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |
| 13a. STATE<br>Md  |  |   | 13b. COUNTY  |   | 13c. CITY OR TOWN<br>Baltimore   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   | 13e. STREET ADDRESS / ZIP CODE<br>1651 N. Smallwood St. 21214   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Harry Bruce   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Myrtle Water          |   |  |   |   |                                   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>219 32 6484 |   | 17. INFORMANT<br>Howard W. Jackson   |   |   | ADDRESS<br>1651 Smallwood St.     |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Massive Subarachnoid Hemorrhage<br>DUE TO, OR AS A CONSEQUENCE OF (b) Aneurysm<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |   |   |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a   |  |   |  |   |  |   |   |                                   |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |                                   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |                                   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/123, 19 84, to 11/8, 19 84, that (I) (we) last saw the deceased alive on 11/8, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                    |  |   |  |   |  |   |   |                                   |   |  |
| 22b. SIGNATURE<br>Lee Freedman  |  |   | DEGREE   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |   | 22c. DATE SIGNED<br>11/8/84       |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Lee Freedman   |  |   | 22e. ADDRESS<br>U. Maryland Hospital 12 S. Greene St.                  |   |  |   |   |                                   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation   |  |   | 23b. DATE<br>11/12/84  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview   |   | 23d. LOCATION<br>CATIONVILLE BALTO. MD.   |                                   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Turnell B. Oden - 1638  |  |   | ADDRESS<br>1638  |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 13 1984   |   | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson  |                                   |   |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHM-17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |                  |   |  |   |  |   |  |  |  |               |  |
|--|------------------|---|--|---|--|---|--|--|--|---------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |                  | FIRST<br>Drenda   |  | MIDDLE  |  | LAST<br>Jackson   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> NOV. 11 28 84 |  | 2b. HOUR<br>M |  |
| 3. SEX<br>FEMALE   | 4. RACE<br>NEGRO | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>FEB 28 1926   |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)<br>58 YRS.   | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN. |   | 7c. DATE PRONOUNCED DEAD<br>NOV 11 28 84 |  | 2d. HOUR<br>4:40 PM                          |               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |  |  |               |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>4205 Flowerton Road |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>NURSING                        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>HOSPITAL  |  |               |  |
| 13a. STATE<br>MARYLAND   |                  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>4205 FLOWERTON ROAD 21229                                       |  |               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>WALTER KING  |                  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>AMANDA THOMAS  |  |   |  |  |  |               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>NO  |                  | (IF YES, GIVE WAR OR DATES)   |  | 16b. SOCIAL SECURITY NO.<br>215-24-4438   |  | 17. INFORMANT<br>CHARLES B. JACKSON/ROAD - 21229  |  | ADDRESS 4205 FLOWERTON   |  |               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |                  |   |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |               |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |                  |   |  |   |  |   |  |  |  |               |  |
| 19a. DATE OF OPERATION   |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |  |               |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |  |  |               |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |               |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                  |   |  |   |  |   |  |  |  |               |  |
| ACTUAL SIGNATURE<br><i>Margarita A. Korell</i>   |                  | TITLE (SPECIFY)<br>M.D. Assistant   |  |   |  | MEDICAL EXAMINER  |  | DATE SIGNED 11/29/84   |  |               |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |                  | Margarita A. Korell, M.D.   |  |   |  | ADDRESS   |  | 111 Penn Street, Balto, MD 21201   |  |               |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |                  | 23b. DATE<br>12/03/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>W. LIBERTY UM CHUR  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>MARRIOTTSTVILLE, Md.                              |  |  |  |               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>MARSHALL W. JONES, JR.<br>ADDRESS<br>4101 EDMONDSON AVE./BALTO., Md. 21229   |                  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 30 1984  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |  |               |  |

2 3 4 5

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 9 4 4

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |   |  |  |   |
|--|--|--|---|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Edward W. Jackson  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 24 84 |   |  | 2b. HOUR<br>M  |   |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 14 07  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Union Memorial Hospital 21218 |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired  |   |
| 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |   |   |  |  |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |   |   |  |  |   |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>--  |   | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Albert Jackson   |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Addie Carr   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>--  |   | 17. INFORMANT ADDRESS<br>Mrs. Erma Jackson 6015 Altamont Place 21210  |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>acute MI</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCUD</u><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.           |  |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>0 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |  |   |   |  |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/1/83</u> , 19 <u>80</u> , to <u>11/21</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |  |  |   |
| 22b. SIGNATURE<br><u>L. Boas</u>   |  | DEGREE   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><u>Nov 26 84</u>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>LAWRENCE BOAS</u>  |  | 22e. ADDRESS<br><u>54 510 H Adam Rd MD 21030</u>   |   |   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>11/28/84  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Mem. Pk.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland   |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>A. Alan Seitz, Jr. 3615-19 Chestnut Ave. 21211   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 28 1984  |  |  |   |
|  |  |  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Rodriguez</u>   |  |  |   |

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 9 4 5

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |   |  |  |  |  |
|--|--|---|--|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ROBERT NATHANIEL JACKSON</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 13 1984</b>               |   |   | 2b. HOUR<br>M<br><b>AM</b>   |  |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>BLACK</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 05 1923</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>61</b> YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>00 00 00 00</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4417 MORAVIA ROAD</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>TRUCK DRIVER</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>FORT MEADE</b>   |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>4417 MORAVIA RD.<br/>APT. 6 BALTIMORE, MARYLAND 21206</b>                             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>FRANK JACKSON SR.</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>IRENE FIELDS</b>   |   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>   |  |   | 16b. SOCIAL SECURITY NO.<br><b>218-14-0382</b>                         |   |   | 17. INFORMANT<br><b>AUDREY GIDDINS</b> ADDRESS<br><b>2307 WHITTIER AVENUE<br/>BALTIMORE, MARYLAND 21217</b>                                |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>GASTRIC CARCINOMA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>   |  |   |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/22/84</b> , 19 <b>84</b> , to <b>10/30</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>10/30</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.              |  |   |  |   |   |  |  |  |  |
| 27b. SIGNATURE<br><b>Nisha Soprey</b>  |  |   |  |   |   | DEGREE   |  | 27c. DATE SIGNED<br><b>11/13/84</b>  |  |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>NISHA SOPREY</b>   |  |   |  |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  |
| 27e. ADDRESS<br><b>2307 GARRISON BLVD<br/>BALTO MD 21216</b>   |  |   |  |   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>CREMATION</b>   |  |   | 23b. DATE<br><b>11/13/1984</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SECURITY PROCESS CREMATORY</b> |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE, MARYLAND</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>NOTTER &amp; SONS</b><br>2501 GWYNNS FALLS PARKWAY<br>FUNERAL HOME INC., BALTIMORE, MARYLAND 21216  |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 14 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Nisha Davidson-Randall</b>  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_



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JACKSON

MATTHEW

ROBERT

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BEACH

MAIR

W. WASHINGTON CITY

U. S. A.

BERNARD

4417 CORVALLA ROAD

BALTIMORE

X

BALTIMORE

BERNARD

THREE

JACKSON ST.

STARK

2307 WHITEHALL AVENUE  
BALTIMORE, MARYLAND 21217

515-1-0982

NO 12

YES

BALTIMORE, MARYLAND

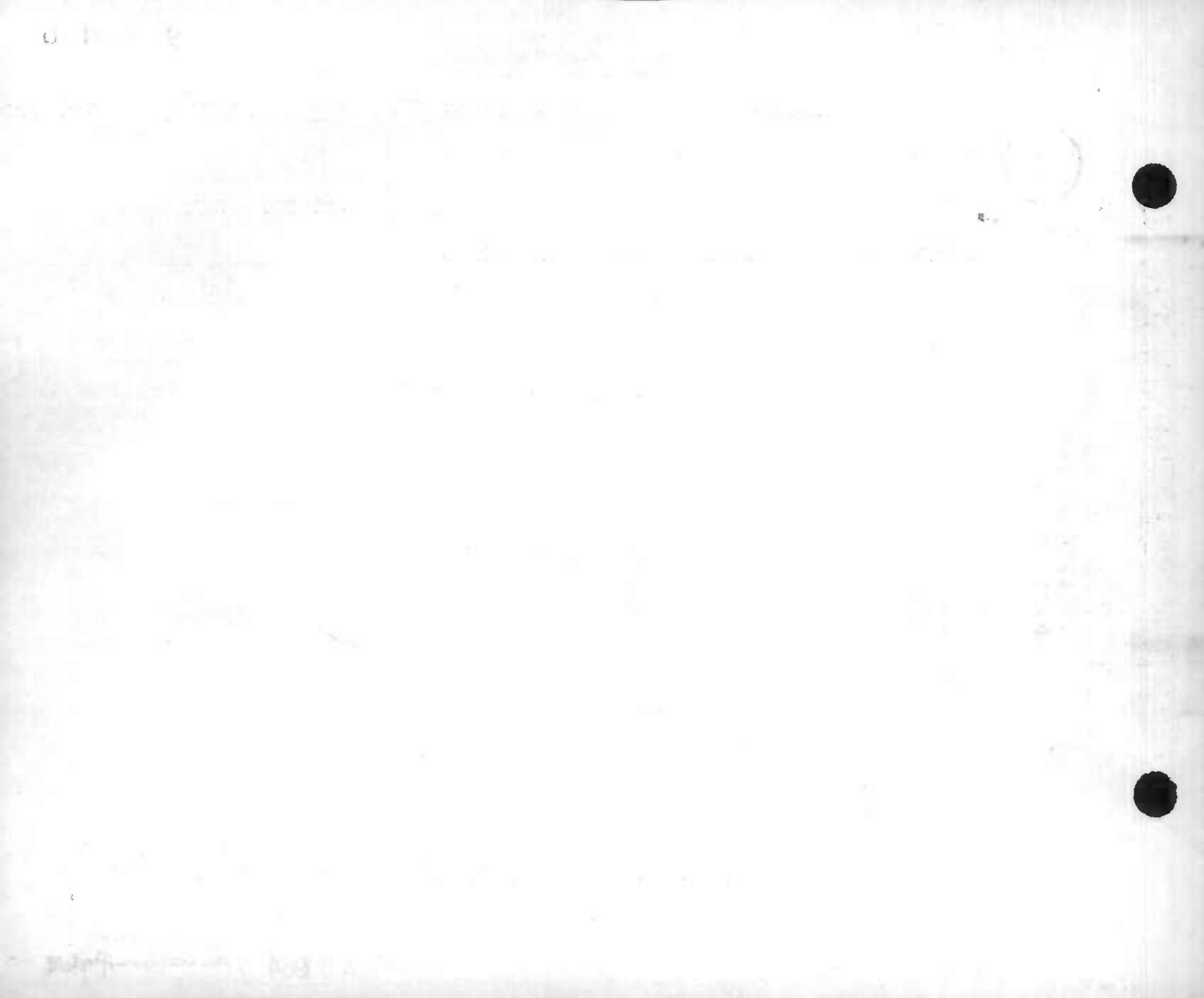
SECURITY PROCESS CENTER

11/13/1984

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Please retain copies of this form. Page 1 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene. Page 2 is to be filed with the local health officer, if available.  
 IMPORTANT: If item 21 is marked on item 18 according to the instructions, the medical examiner must be notified of the death.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |                                |  | 8 4 2 9 9 4 6                                   |     |                |          |
|---|--|---|--|---|--|---|--|--------------------------------|--|---|-----|----------------|----------|
| 1. FOR<br>STATE<br>REGISTRAR  |  |   |  |   |  |   |  |                                |  | REG. NO.  |     |                |          |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH              |  | MONTH   | DAY | YEAR           | 2b. HOUR |
| ROLAND  |  | JACKSON   |  | SR.   |  |   |  | 11/22/84                       |  |   |     | 10:00AM        |          |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR                |  | IF UNDER 24 HRS                                 |     |                |          |
| Male  |  | Black   |  | 3 1 34  |  | 50 YRS.   |  | MONTHS                         |  | DAYS  |     | HOURS MIN.     |          |
| 7a. BIRTHPLACE<br>(COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                |  |   |     |                |          |
| MD  |  | USA   |  |   |  | BALTIMORE CITY  |  |                                |  |   |     | MD             |          |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                                |  |   |     |                |          |
| BALTIMORE   |  | JOHNS HOPKINS HOSPITAL  |  |   |  |   |  |                                |  |   |     |                |          |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS / ZIP CODE |  |   |     |                |          |
| MD  |  |   |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 1004 N. Patterson PK. Ave.     |  |   |     | 21205          |          |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |  |   |  |   |  |                                |  |   |     |                |          |
| Charles   |  | Jackson   |  | Dorothy   |  | Anderson  |  |                                |  |   |     |                |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT   |  | ADDRESS   |  |                                |  |   |     |                |          |
| No  |  | 219-32-5226   |  | Chlorice Jackson  |  | 2009 E. Preston St.   |  |                                |  |   |     |                |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u>   |  |   |  |   |  |   |  |                                |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |     | <u>minutes</u> |          |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____   |  |   |  |   |  |   |  |                                |  |   |     |                |          |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |   |  |   |  |   |  |                                |  |   |     |                |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><u>seizures / hypertension</u>  |  |   |  |   |  |   |  |                                |  |   |     |                |          |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?   |  |                                |  |   |     |                |          |
|   |  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                                |  |   |     |                |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)  |  |   |  |                                |  |   |     |                |          |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |                                |  |   |     |                |          |
|   |  |   |  |   |  |   |  |                                |  |   |     |                |          |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/22</u> 19 <u>84</u> , to <u>11/22</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>11/22</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |                                |  |   |     |                |          |
| 22b. SIGNATURE<br><u>Mindy Shapiro</u>  |  | DEGREE<br>MD  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br>11/22 84  |  |                                |  |   |     |                |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |  |   |  |   |  |                                |  |   |     |                |          |
| MINDY SHAPIRO, M. D.  |  | THE JOHNS HOPKINS HOSPITAL  |  | 600 N. WOLFE ST. BALTO. MD. 21205   |  |   |  |                                |  |   |     |                |          |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |                                |  |   |     |                |          |
| Burial  |  | 11/28/84  |  | Mt. Zion Cem.   |  | Baltimore   |  |                                |  |   |     | MD             |          |
| 24. FUNERAL DIRECTOR<br>NAME  |  | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |                                |  |   |     |                |          |
| Wm. C. March F/H  |  | 1101 E. North Ave.  |  | NOV 28 1984   |  | <u>Julia Davidson-Rodriguez</u>                                     |  |                                |  |   |     |                |          |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

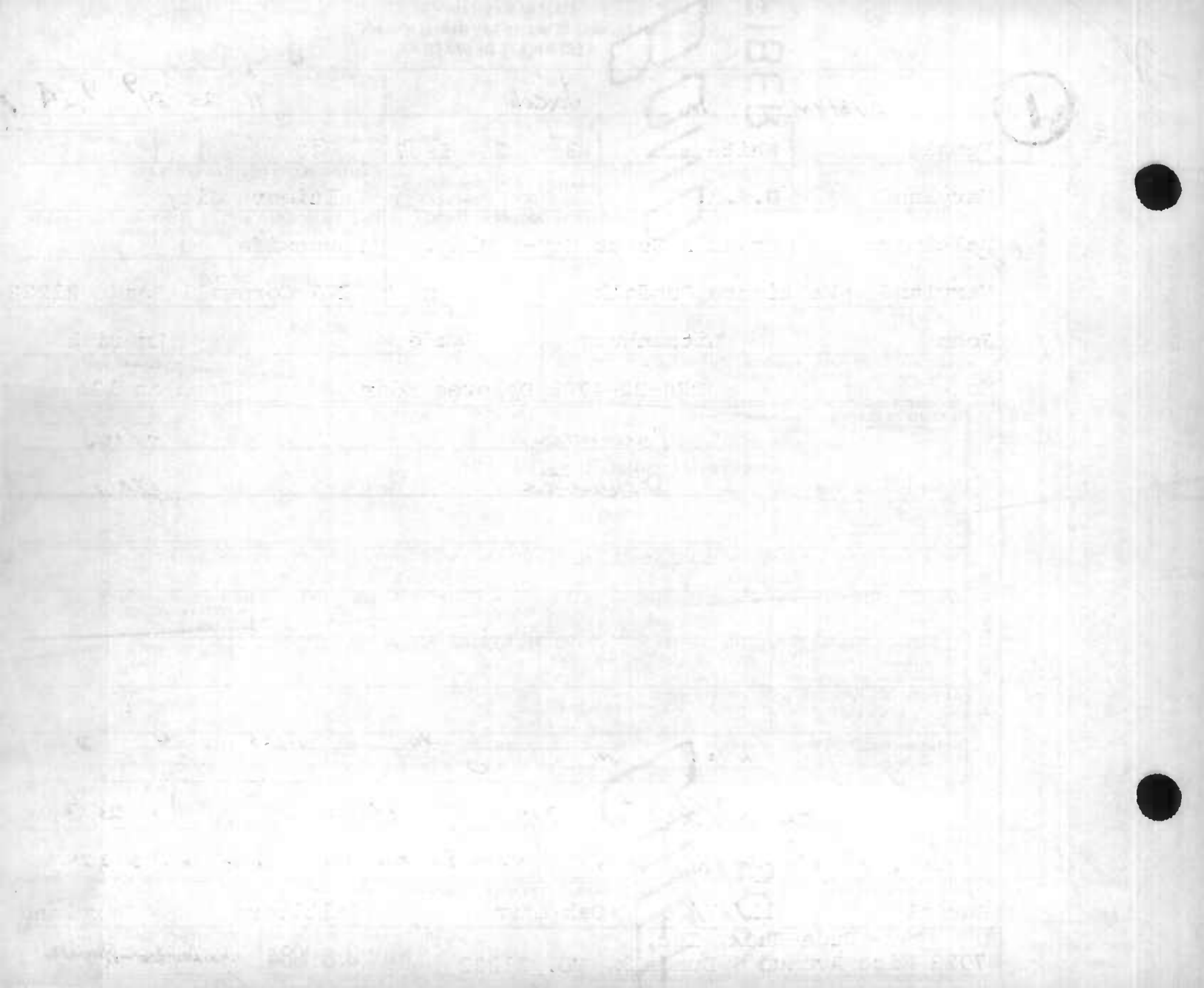
IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified and advised.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |                             |  |  |
|--|--|---|--|---|-----------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Evelyn M. Jacob</i>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>11 25 84</i> |   | 2b. HOUR<br><i>12:45 PM</i> |  |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>White</i>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>3 28 1907</i>  |                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>77</i> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Francis Scott Key-D Bldg.</i> |  |   |                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Housewife</i>                                       |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. CITY OR TOWN 13c. INSIDE CITY LIMITS?<br><i>Maryland Baltimore Dundalk</i><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13d. STREET ADDRESS / ZIP CODE<br><i>3122 Cornwall Road 21222</i>   |  |   |                             |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>John Litzenburg</i>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Maude Emerick</i>   |                             |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>220-22-4701</i>   |  | 17. INFORMANT<br><i>Dolores Eder</i>  |                             | ADDRESS<br><i>Same as 13e</i>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Pneumonia</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Dementia</i><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>4 days</i><br><i>years</i> |  |   |  |   |                             |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |   |                             |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                             | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |                             |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                             |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11/25</i> <i>1984</i> to <i>11/25</i> <i>1984</i> , that (I) (we) last saw the deceased alive on <i>11/25</i> <i>1984</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |                             |  |  |
| 22b. SIGNATURE<br><i>John R. Burton</i>  |  |   |  | DEGREE<br><i>MD</i>   |                             | 22c. DATE SIGNED<br><i>11/25/84</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>John R. Burton MD</i>  |  |   |  | 22e. ADDRESS<br><i>5200 Eastern ave Balto. md 21224</i>   |                             |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>11/27/84</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Oak Lawn</i>   |                             | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore Maryland</i>  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, MD. 21222</i>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>NOV 28 1984</i>   |                             |  |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>  |                             |  |  |

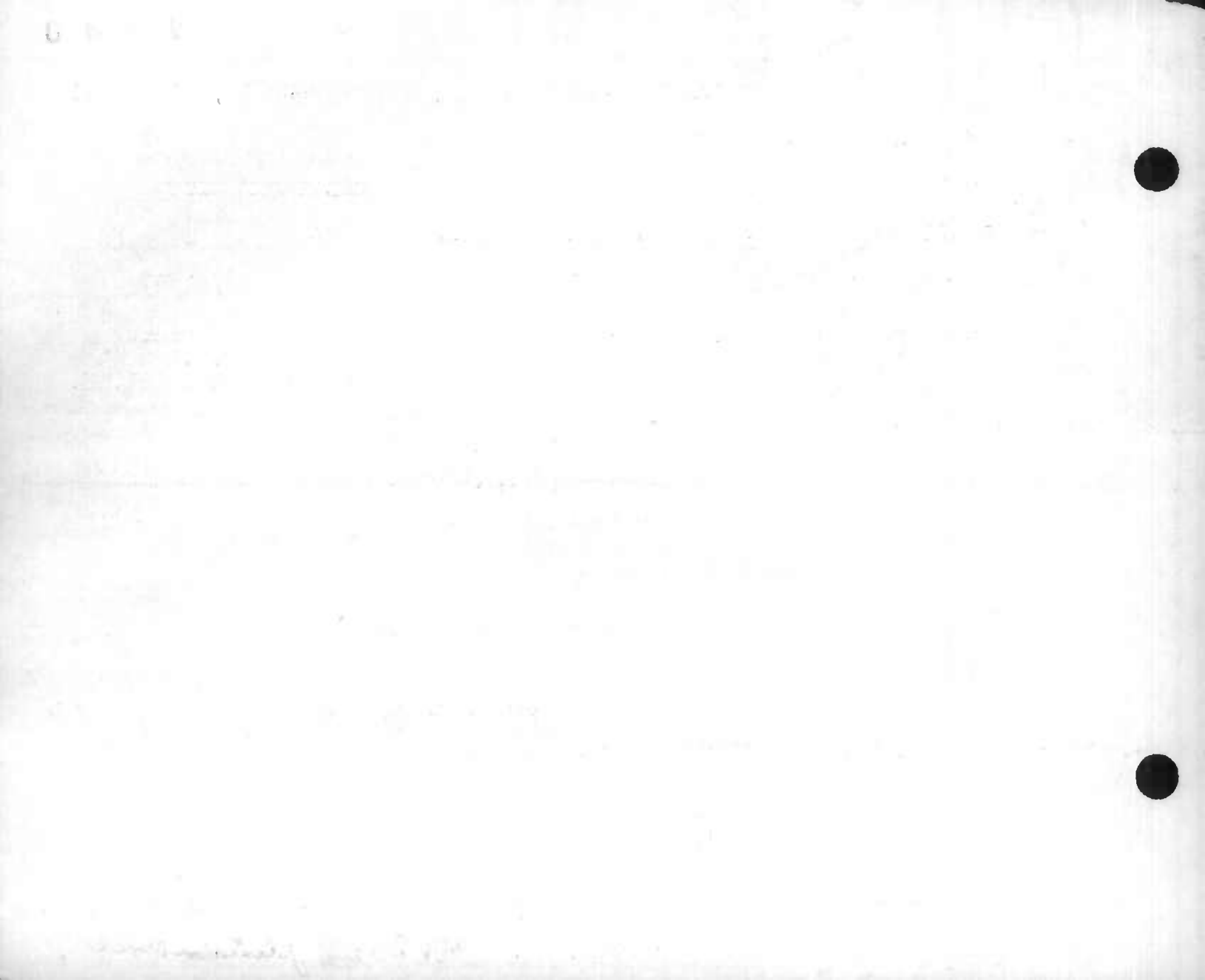
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon copy of page 4 and 2 under the heading "In 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body." and send them to the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report filed.

| 1- STATE REGISTRAR   |  | STATE OF MARYLAND   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  | 8 4 2 9 9 4 8   |  |
|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   |  | 2a. DATE OF DEATH  |  | 2b. HOUR  |  |
| ANNE LORRAINE JACOBSON   |  |   |  | NOVEMBER 21, 1984  |  | 2:30 P M  |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |
| female   |  | caucasian   |  | 11 20 84   |  | YRS. 1 MONTHS 1 DAYS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |
| Maryland   |  | USA   |  |  |  | BALTIMORE CITY MD.  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| BALTIMORE  |  | JOHNS HOPKINS HOSPITAL  |  | NA   |  | NA  |  |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  |
| Maryland   |  | Talbot  |  | McDaniel   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  |
| Richard Roy Jacobson   |  | Jane Bridges  |  | NO   |  | NA  |  |
| 17. INFORMANT  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  | 17. ADDRESS  |  | 17. P.O. Box 44   |  |
| Richard R. Jacobson  |  | Cardiorespiratory Arrest  |  | P.O. Box 44  |  | McDaniel, Md.   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
|  |  | Renal Vein Thrombosis   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
|  |  | P.M. 19   |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
|  |  |   |  | 600 N. Wolfe St. Baltimore MD  |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from 11/20 19 84, to 11/21 19 84, that (1) (we) lost saw the deceased alive on 11/21 19 84, and that (1) (we) (did not) view the body after death. |  | 22b. SIGNATURE  |  | 22c. DATE SIGNED   |  |   |  |
|  |  | Paul C. Brewer MD   |  | 11/21/84   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |  |
| cremation  |  | 11-26-84  |  | Delmarva Crematory   |  | Sussex Del.   |  |
| 24. FUNERAL DIRECTOR NAME  |  | 24. ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |
| Newnam Funeral Home  |  | Easton, Md.   |  | NOV 29 1984  |  | John E. Davidson  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |   |   | REG. NO. 3 4 2 9 9 4 9   |  |
|--|--|---|--|---|--|--|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>Rev. JOHN Thomas JAMAR   |  |   |  |   |  | 2a. DATE OF DEATH<br>11/30/84  |  |   | 2b. HOUR<br>6P M                          |  |  |
| 3 SEX<br>MALE  |  | 4. RACE<br>BLACK  |  | 5. DATE OF BIRTH<br>11 3 97   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>87 YRS  |  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Ala. USA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balto. MD.   |  |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>FED. HILL NURSING CENTER |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |   | 12b. KIND OF BUSINESS OR INDUSTRY         |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |  | 13a. STATE<br>MD   |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br>Balto   |  |
| 14. FATHER'S NAME<br>David   |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>Mary E.  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br>1213 Light St 21230  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  |   |  |   |  | 16b. SOCIAL SECURITY NO.<br>418-01-2329  |  | 17. INFORMANT<br>Helen Leak ADDRESS   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Atherosclerotic Cardiovascular disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Chronic Renal failure<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) S.P. Pneumonia RLL     |  |   |  |   |  |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>several yrs<br>2 yrs<br>3 mo   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>U.T.D.   |  |   |  |   |  |  |  |   |   |  |  |
| 19a. DATE OF OPERATION<br>2/9  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/2/84, to 11/30/84, that (I) (we) last saw the deceased alive on 11/4/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |   |   |  |  |
| 22b. SIGNATURE<br>Donatun H. Naeem MD  |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |   | 22c. DATE SIGNED<br>12/1/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>AMATUN H NAEEM  |  |   |  |   |  | 22e. ADDRESS<br>501 Dolphin St, Balto MD 21217   |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |   |  | 23b. DATE<br>12-6-84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Shadow Lawn Cem  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Birmingham Ala.                                   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leroy O. Dyett   |  |   |  |   |  | ADDRESS<br>4600 Liberty Hgts. Ave  |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 3 1984   |   | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |  |

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Thomas D. H.

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James Mary E.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 29950   |  |  |   |
|---|--|---|--|--|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Harvey James</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>11/22/84</b>  |  |  |   |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>08 29 97</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b> YRS.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD</b>   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSP</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William James</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>SARAH COOK</b>  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>5421 PRICE AVE 21215</b>  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>231 586 355</b>  |  | 17. INFORMANT<br><b>MRS BRENDA PLATE 5421 PRICE AVE 21215</b>  |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio pulmonary Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Prostatic CA</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic heart disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5-10 min</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |   |  |  |  |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/22/84</b> 19 <b>84</b> to <b>11/22</b> 19 <b>84</b> , that (I) (we) lost <b>saw the deceased alive on</b> above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |  |   |
| 22b. SIGNATURE<br><b>Paul H. Lunge / 9260</b>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>     |  | 22c. DATE SIGNED   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |  |  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SEE 17)   |  | 23b. DATE<br><b>17-2-84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GLADENSTEIN FIELD CEM</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>GLADENSTEIN CO. VA</b>  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Joseph L. Ross</b>   |  | ADDRESS<br><b>2222 W. NORTH AVE</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 29 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |   |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 4 2 9 9 5 1  
REG. NO.FOR  
1. STATE  
REGISTRAR

|  |  |   |   |  |   |
|--|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JOSEPH FRANK JAMES</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 11 84</b>  |  | 2b. HOUR<br><b>1:14 PM</b>                                  |
| 3 SEX<br><b>Male M</b>   | 4 RACE<br><b>White C</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 22, 1913</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.                              |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NY</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>              |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIV. OF MD. CANCER CENTER</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Officer</b>              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Foreign Service</b> |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>  | 13b. COUNTY<br><b>Montgomery</b>   | 13c. CITY OR TOWN<br><b>Bethesda</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Christos James</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Catherine Vouziakas</b>   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Yes WW II</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>579-48-9479</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Catherine P. James same as item # 13</b>        |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Fungal sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>acute non lymphocytic leukemia</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b><br><b>4 weeks</b> |  |   |   |  |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |   |   |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |   |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/19</b> , 19 <b>84</b> , to <b>11/11</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>11/11</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |  |   |
| 22b. SIGNATURE<br><b>Richard Nora</b>  |  | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED<br><b>11/11/84</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RICHARD NORA M.D.</b>  |  | 22e. ADDRESS<br><b>UNIV. OF MARYLAND CANCER CENTER</b>  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11/14/84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>               |   |
| 23d. LOCATION<br>CITY OR TOWN<br><b>Suitland, MD</b>   |  | COUNTY<br><b>MD</b>   |   | STATE  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Joseph Gawler's Sons, Inc.</b><br>ADDRESS<br><b>5130 Wis. Ave. N.W. Wash., DC 20016</b>   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 16 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Davidson</b>               |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18 shows any injury, or other traumatic event, the medical examiner must be advised at once.

BP

11 11 84 10 4

JOSEPH J. FRANK JAMES

Age M Date 10/10/1913

BALTIMORE CITY

WV. 60 40. CANCER CENTER

5018 Cedar Lane

1913

1913

Funeral service

4 weeks

11 11 84 10 4

11/11

WV. 60 40. CANCER CENTER





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8429952  
REG. NO.

FOR  
1- STATE  
REGISTRAR

|  |  |   |   |   |   |  |  |
|--|--|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Charles G. Januska                  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 1 84                |   |   | 2b. HOUR<br>132 P M  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>05 02 07  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS.                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD. |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Mercy Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Breeder + Trainer   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Horses                |  |
| 13a. STATE<br>Md.  |  |   | 13b. CITY OR TOWN<br>Woodbine                                 |   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Gabriel JANUSKA                  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna Deftuva |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>217 05 9992  |   | 17. INFORMANT<br>ADDRESS<br>Adelaide O. Januska Woodbine, Md.   |   |  |  |

|  |  |   |  |
|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) sepsis<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) sideroblastic anemia<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
|--|--|---|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from 10-20 19 84, to 11-1 19 84, that (I) (we) lost<br>saw the deceased alive on 11-1 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br>George M. Boyer MD  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>10-1-84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>George M. Boyer  |  |  |  | 22e. ADDRESS<br>Mercy Hospital   |  |   |  |

|   |  |                      |  |   |  |   |  |
|---|--|----------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation   |  | 23b. DATE<br>11-5-84 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Carrick Cemetery Harris |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Hampstead Carroll Md. |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Harry W. Haight Lykens, Md. |  |                      |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 2 1984                   |  | 25b. REGISTRAR'S SIGNATURE<br>Lia Davidson-Randall                  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## CERTIFICATE OF DEATH

REG. NO.

8 4 2 9 9 5 3

|  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  | 2a. DATE OF DEATH  |  |  | 2b. HOUR   |  |  |
| I. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST MIDDLE LAST  |  |  | MONTH DAY YEAR   |  |  |
| Harry Jaskulsky  |  |  |  |  |  | 11 5 84  |  |  |
| 3. SEX   |  |  | 4. RACE  |  |  | 5. DATE OF BIRTH   |  |  |
| MALE   |  |  | WHITE  |  |  | MONTH DAY YEAR   |  |  |
|  |  |  |  |  |  | NOV. 10, 1911  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |  |
| MARYLAND   |  |  | USA  |  |  | 72 YRS.  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |
| BALTIMORE  |  |  | ST. AGNES HOSPITAL   |  |  | BALTIMORE CITY MD.   |  |  |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  | 12c. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |  |  |
| 13a. STATE   |  |  | 13b. COUNTY  |  |  | 13c. STREET ADDRESS / ZIP CODE   |  |  |
| MARYLAND   |  |  | BALTO.   |  |  | 2804 DAMASCUS CT. #21209   |  |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  | 16. SOCIAL SECURITY NO.  |  |  |
| FIRST MIDDLE LAST  |  |  | FIRST MIDDLE LAST  |  |  | 17. INFORMANT  |  |  |
| SIMON JASKULSKY  |  |  | IDA KAMINKOW   |  |  | MRS. EVA JASKULSKY APT. D  |  |  |
| 18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  | 18b. SOCIAL SECURITY NO.   |  |  | 18c. DATE OF OPERATION   |  |  |
| YES  |  |  | WWII=NAVY  |  |  | 215-07-1726  |  |  |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  | 20. DATE OF OPERATION  |  |  | 21. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |  |  |
| PART 1. DEATH WAS CAUSED BY:   |  |  | 22a. AUTOPSY?  |  |  | 22b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?                 |  |  |
| IMMEDIATE CAUSE (a) SEPTIC SHOCK   |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                    |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |
| (b) NEPHROTIC SYNDROME   |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |
| (c) ACUTE RENAL FAILURE  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |
|  |  |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |  |  |
|  |  |  | P.M. 19  |  |  |  |  |  |
| 21d. INJURY OCCURRED   |  |  | 21e. PLACE OF INJURY   |  |  | 21f. LOCATION  |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | CITY OR TOWN COUNTY STATE  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Aug 28, 19 84, to Nov 5, 19 84, that (I) (we) lost saw the deceased alive on Nov 5, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE   |  |  | DEGREE   |  |  | 22c. DATE SIGNED   |  |  |
| Paul Turer   |  |  | MD   |  |  | 11/5/84  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  | 22e. ADDRESS   |  |  | 22f. REGISTRAR'S SIGNATURE   |  |  |
| PAUL TURER   |  |  | ST. AGNES HOSPITAL<br>900 CATON AVE, BALTO. MD 21209   |  |  | Julia Davidson-Randall   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  | 23b. DATE  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |
| BURIAL   |  |  | NOV. 6, 1984   |  |  | BNAI JACOB   |  |  |
| 23d. LOCATION  |  |  | 23e. DATE REC'D. BY REGISTRAR  |  |  | 23f. REGISTRAR'S SIGNATURE   |  |  |
| CITY OR TOWN COUNTY STATE  |  |  | NOV 13 1984  |  |  | Julia Davidson-Randall   |  |  |
| BALTIMORE MARYLAND   |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR'S NAME  |  |  |  |  |  |  |  |  |
| SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD. BALTO., MD 21215   |  |  |  |  |  |  |  |  |

MEDICAL CERTIFICATION



BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

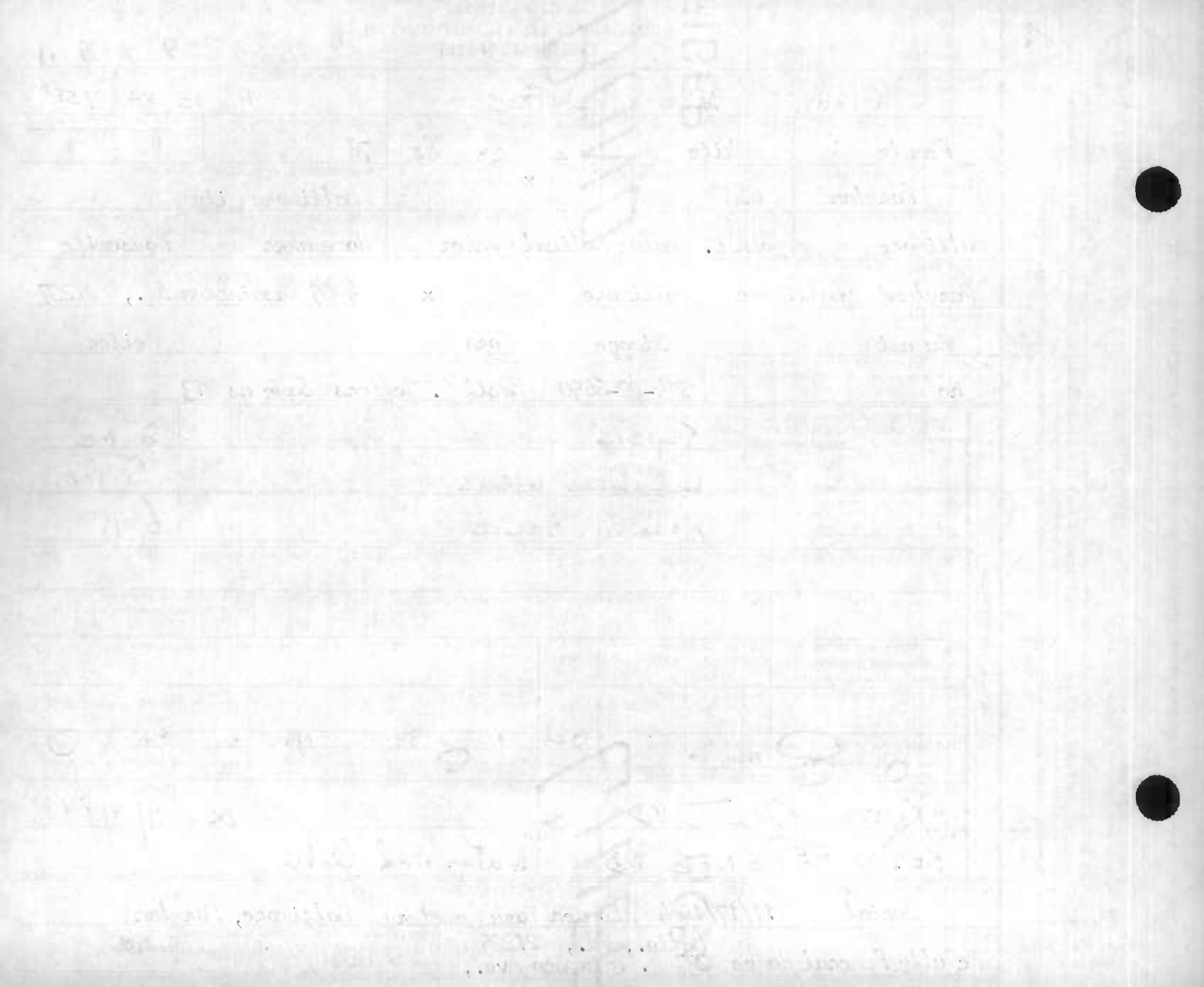
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |   |   |  |  |   |
|--|--|---|--|---|---|---|--|--|---|
| 1. FOR STATE REGISTRAR   |  |   |  |   | 8 4 2 9 9 5 4<br>REG. NO.                                 |   |  |  |   |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Gladys Mae Jeffers  |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>11 13 84              |   |  | 2b. HOUR<br>7 55 P M   |   |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>4 28 08  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS.  |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |   |
| 7a. BIRTHPLACE (COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                    |  |  |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>John L. Deaton Medical Center |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Housewife   |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE COUNTY<br>Maryland Baltimore   |  | 13b. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 13e. STREET ADDRESS / ZIP CODE<br>4005 Washington St., 21227                                  |  |  |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>August Stagge   |  |   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Cora Reiter |   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)<br>no   |  | 16b. SOCIAL SECURITY NO.<br>214-22-6690   |  | 17. INFORMANT ADDRESS<br>Basil J. Jeffers Same as #13   |   |   |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Sepsis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Decubitus ulcers</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Alzheimer's Disease</u>   |  |   |  |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 mo.<br>5 mo.<br>6 yr. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 18  |  |   |  |   |   |   |  |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                     |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 9</u> 19 <u>84</u> to <u>Nov 13</u> 19 <u>84</u> , that (I) (we) last saw the deceased <u>Nov 13</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |   |   |  |  |   |
| 22b. SIGNATURE<br>Kevin Ferente MD   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   |   |  | 22c. DATE SIGNED<br>11/14/84   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>KEVIN FERENTE MD  |  |   |  | 22e. ADDRESS<br>Deaton Med Center   |   |   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>11/17/1984   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cemetery  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland                             |  |  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>McCutty Funeral Homes  |  |   |  | 24b. ADDRESS<br>Baltimore, Md., 21225<br>237 E. Patapsco Ave.   |   | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br>NOV 19 1984 Julia Davidson-Rodell |  |  |   |



07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))

Items 18-22a 1/7/85 mth F#599

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4 REG. NO.

|  |  |                         |  |  |  |  |  |   |  |                                  |  |   |  |  |  |   |  |  |  |
|--|--|-------------------------|--|--|--|--|--|---|--|----------------------------------|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Carlton Jenkins</b>   |  |                         |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> 11-25 19 84   |  |  |  | 2b. DATE OF DEATH<br>MONTH DAY YEAR 11-25 19 84   |  |                                  |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR 11-25 19 84  |  |  |  | 2d. HOUR OF DEATH<br>5  |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR 8 17 52   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY 32 YRS. |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN  |  | 8. IF UNDER 24 HRS.<br>HOURS MIN |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b> MD.                              |  |  |  |   |  |  |  |
| 1a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto., Md.</b>  |  |                         |  | 1b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |  | 1c. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                  |  | 1d. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b> MD.                             |  |  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Lutheran Hospital</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>City Worker</b>   |  |                                  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>none</b>  |  |  |  |   |  |  |  |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b>  |  |                         |  | 13b. COUNTY  |  |  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  |                                  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  | 13e. STREET ADDRESS<br><b>3111 Presbury St.</b> 21216                     |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Bruce Jenkins</b>   |  |                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lillian E. Tilghman</b>  |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>no</b>  |  |                                  |  | 16b. SOCIAL SECURITY NO.<br><b>214-56-7797</b>  |  |  |  | 17. INFORMANT<br><b>Bruce Jenkins</b> ADDRESS<br><b>3111 Presbury St.</b> |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gunshot wound of Chest</b><br><b>Multiple Gunshot Wounds</b> (unspecified)<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                             |  |                         |  |  |  |  |  |   |  |                                  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                         |  |  |  |  |  |   |  |                                  |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |   |  |                                  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |  |  |   |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH<br><input checked="" type="checkbox"/> <b>XX</b>   |  |                         |  | 21b. TIME OF INJURY<br>HOUR MONTH DAY YEAR 9:25 P.M. 11-25 19 84   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM TB PART 1 OR PART 2)<br><b>subject was shot</b>  |  |                                  |  |   |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> <b>XX</b>  |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>Home</b>   |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>3111 Presbury Street, Baltimore, Maryland</b>   |  |                                  |  |   |  |  |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                         |  |  |  |  |  |   |  |                                  |  |   |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE<br><i>Dennis F. Smyth</i>   |  |                         |  | TITLE (SPECIFY)<br><b>M.D. Assistant</b>   |  |  |  | MEDICAL EXAMINER  |  |                                  |  | DATE SIGNED<br><b>11-26-84</b>  |  |  |  |   |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Dennis F. Smyth, M.D.</b>   |  |                         |  | ADDRESS<br><b>111 Penn St., Balto., Md. 21201</b>  |  |  |  |   |  |                                  |  |   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |                         |  | 23b. DATE<br><b>11-30-84</b>   |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cemetery</b>  |  |                                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                         |  |  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. Brown Comm. F.H.</b>   |  |                         |  | ADDRESS<br><b>1206-08 W. North Ave.</b>  |  |  |  | 25a. DATE REC'D BY REGISTRAR<br><b>NOV 28 1984</b>  |  |                                  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Jane Gordon</i>  |  |  |  |   |  |  |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Area 20 below

3110 1/2

3110 1/2



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. (Page 4 may be retained by the hospital or attending physician.)

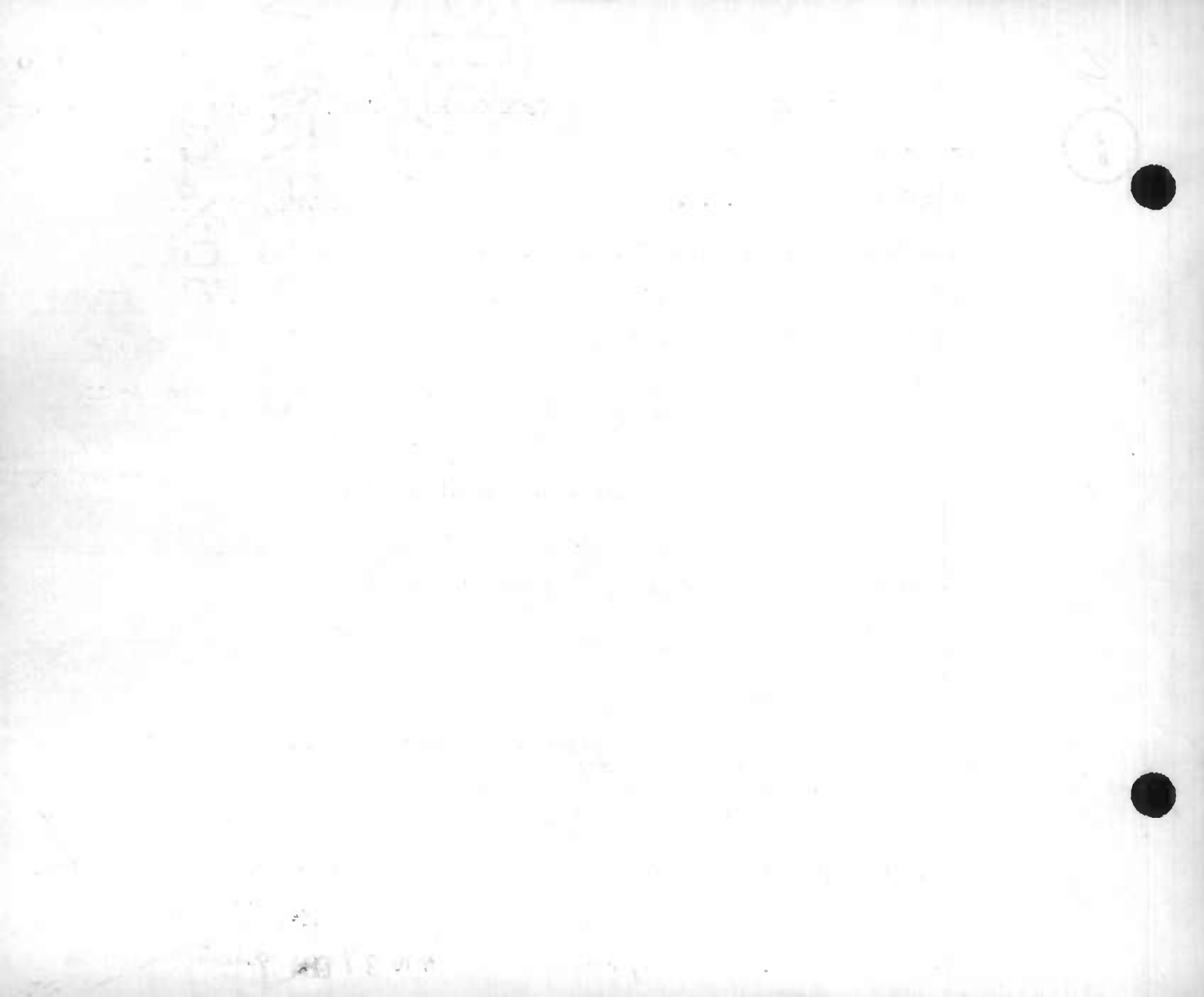
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 9 5 6  
REG. NO.

|  |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST MIDDLE LAST<br>COURTNEY M JENNINGS  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>NOV. 25, 1984  |  | 2b. HOUR<br>11:45am  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>September 10, 1984  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS MONTHS DAYS<br>2 15                                      |  | IF UNDER 1 YEAR<br>IF UNDER 24 HRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>JOHNS HOPKINS HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>None                        |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>5900 Plumer Ave 21206  |  |
| 14. FATHER'S NAME<br>Jonathan D Jennings   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>Teresa M Ebaugh   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>None  |  | 17. INFORMANT ADDRESS<br>Mr Jonathan D Jennings Same As 13e   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>congenital heart disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>presumed asphyxiation</u>  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>11/25/84</u><br><u>Birth 9/10/84</u>                                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>Biliary / Hepatic Dysfunction</u>  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21i. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/24/84</u> , 19 <u>84</u> , to <u>11/25</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>11/25</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Neal M. Kotin MD</u>  |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  |   |  | 22c. DATE SIGNED<br><u>11/25/84</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>NEAL M. KOTIN</u>  |  |   |  | 22e. ADDRESS<br><u>JOHNS HOPKINS HOSPITAL</u>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Burial</u>  |  | 23b. DATE<br><u>11/28/84</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Moreland Mem Park</u>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Baltimore, Maryland</u>                        |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Leonard J Ruck Inc. Baltimore, Maryland</u>   |  |   |  | ADDRESS   |  | DATE REC'D. BY REGISTRAR<br><u>NOV 27 1984</u>  |  | REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Randall</u>   |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

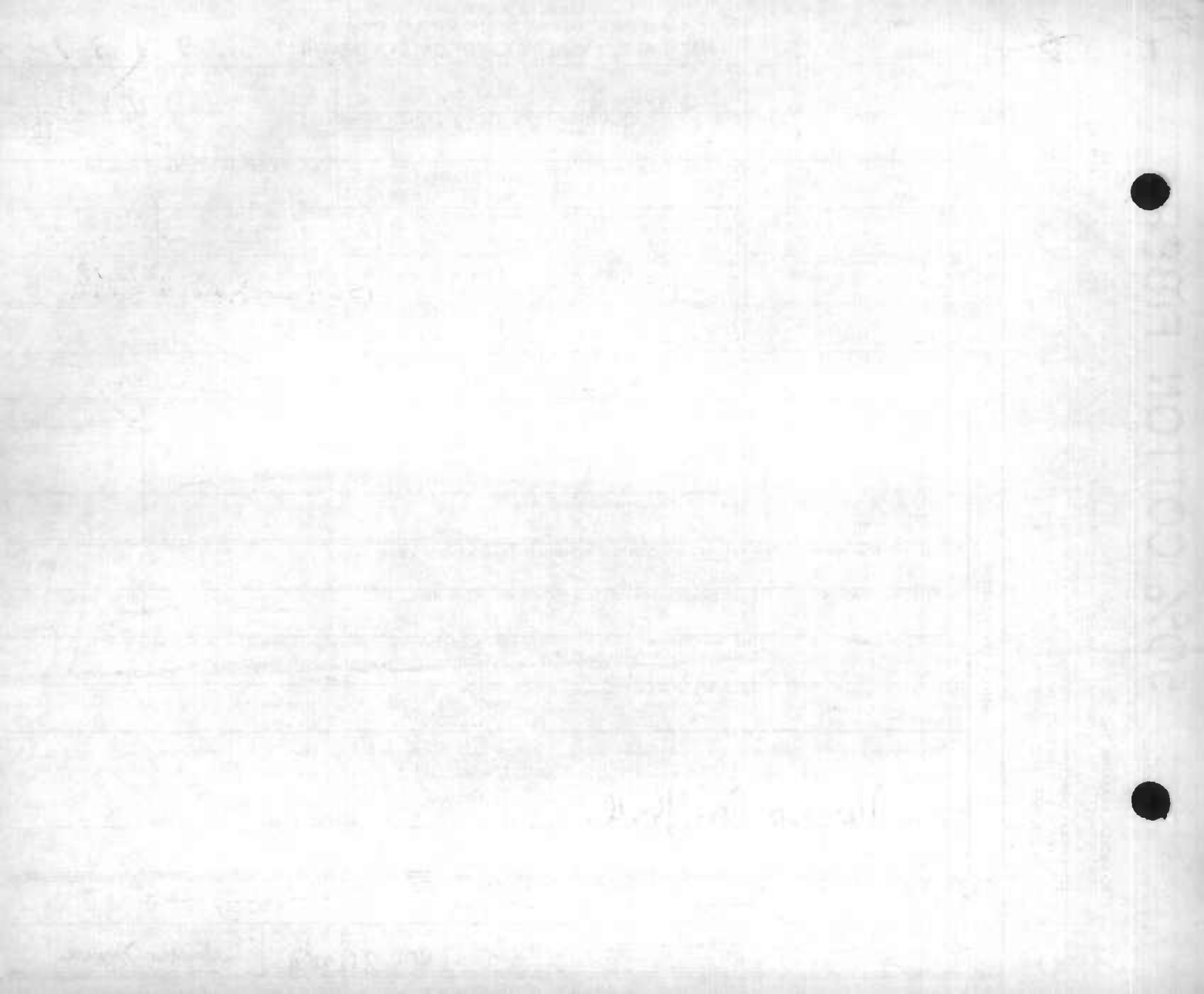
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REC'D NO. 29957

|  |  |                      |  |   |  |  |  |  |  |  |  |  |  |     |  |
|--|--|----------------------|--|---|--|--|--|--|--|--|--|--|--|-----|--|
| 1. FOR STATE REGISTRAR   |  |                      |  |   |  |  |  |  |  | 2a. DATE KNOWN OF DEATH                  |  | 2b. HOUR   |  |     |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Maurice Gregory Jennings</b>   |  |                      |  |   |  |  |  |  |  | 2a. DATE KNOWN OF DEATH <b>11/17/84</b>  |  | 2b. HOUR <b>12:52</b>  |  |     |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>Black</b> |  | 5. DATE OF BIRTH <b>3 14 57</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>27 YRS.</b> |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN   |  | 2c. DATE PRONOUNCED DEAD <b>11/17/84</b> |  | 2d. HOUR <b>A M</b>  |  |     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto. Md.</b>  |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>                       |  | MD. |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hospital Shock Trauma</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Phos. &amp; Draper. -Self employed</b>  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |     |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                      |  | 13a. STATE <b>Maryland</b>  |  |  |  | 13b. COUNTY  |  |  |  | 13c. CITY OR TOWN <b>Baltimore</b>   |  |     |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Lewis Jennings</b>  |  |                      |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Natalie LaProde</b>   |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  | 13e. STREET ADDRESS <b>1554 Lochwood Road</b>                                    |  |     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>  |  |                      |  | 16b. SOCIAL SECURITY NO. <b>217-62-6127</b>   |  |  |  | 17. INFORMANT <b>Sister Mrs. Joyce Smith</b>   |  |  |  | ADDRESS <b>-3712 Mohawk Ave.</b>   |  |     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gunshot Wound of Head</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |                      |  |   |  |  |  |  |  |  |  |  |  |     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |                      |  |   |  |  |  |  |  |  |  |  |  |     |  |
| 19a. DATE OF OPERATION   |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |  |  |  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |     |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                      |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>10:50PM 11/16/84</b>  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>subject shot</b>  |  |  |  |  |  |     |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>street</b>   |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>1200 Block of West North Ave., Balto. City, Md.</b>  |  |  |  |  |  |     |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                      |  |   |  |  |  |  |  |  |  |  |  |     |  |
| ACTUAL SIGNATURE <b>Margarita A. Korell</b>  |  |                      |  | TITLE (SPECIFY) <b>M.D. Assistant</b>   |  |  |  | DATE SIGNED <b>11/17/84</b>  |  |  |  |  |  |     |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>   |  |                      |  | ADDRESS <b>111 Penn St.</b>   |  |  |  |  |  |  |  |  |  |     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |                      |  | 23b. DATE <b>11-21-84</b>   |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>King Memorial Park</b>   |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Randallstown, Maryland</b>            |  |     |  |
| 24. FUNERAL DIRECTOR NAME <b>James A. Morton &amp; Sons</b>  |  |                      |  | ADDRESS <b>1701 Laurens Street</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>NOV 20 1984</b>   |  |  |  | 25b. REGISTRAR'S SIGNATURE <b>Gabe Davidson-Randall</b>                          |  |     |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 9 5 8

REG. NO.

|   |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>LOUISE H JIRRETT</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11-4-84</b>   |  |  | 2b. HOUR<br><b>7:30 P.M.</b>   |  |  |
| 3. SEX<br><b>Female</b>   |  |  | 4. RACE<br><b>Col.</b>   |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7-6-1900</b>  |  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS.   |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>W. VA.</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Provident Hosp</b> |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Home maker</b>  |  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY   |  |  | 13a. STREET ADDRESS<br><b>2735 W. North Ave. 21216</b>   |  |  |  |  |  |
| 13b. COUNTY<br><b>Mar</b>   |  |  | 13c. CITY OR TOWN<br><b>BALTO.</b>   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Burrell Harris</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>SARA Harris</b>  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>NO</b>  |  |  | 17. INFORMANT<br>ADDRESS<br><b>Mr. Lionel Siggett 2735 W. North Ave.</b>   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE CARDIAC ARREST.</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>ATHEROSCLEROTIC HEART DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>CARCINOMA OF LUNG</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-4-84</b> , 19____, to <b>11-4-84</b> , 19____, that (I) (we) last saw the deceased alive on <b>11-4-84</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Krishan Mathur</b>   |  |  | DEGREE<br><b>MD</b>  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11-4-84</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KRISHAN MATHUR</b>  |  |  | 22e. ADDRESS<br><b>2600 Liberty HHS Baltimore MD 21215</b>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE, IF)   |  |  | 23b. DATE<br><b>11-9-84</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Maryland Nat Cem</b>  |  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MD</b>   |  |  | 23e. DATE REC'D. BY REGISTRAR<br><b>NOV 9 1984</b>   |  |  | 23f. REGISTRAR'S SIGNATURE<br><b>John Davidson-Pandell</b>   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Joseph L. Russ 2222 W. North Ave</b>   |  |  |  |  |  |  |  |  |

MEDICAL CERTIFICATION

BP

COPIES

10/10/50

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 4 2 9 9 5 9

|   |  |  |  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |
|---|--|--|--|--|--|---|--|--|---|--|--|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MIRIAM</b>  |  |  | FIRST<br><b>G</b>  |  |  | MIDDLE<br><b>JOFFEE</b>   |  |  | LAST  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov 27 1984</b>  |  |  | 2b. HOUR<br><b>10:45 A.M.</b>                       |  |  |
| 3. SEX<br><b>FEMALE</b>   |  |  | 4. RACE<br><b>WHITE</b>  |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JUNE 7, 1895</b>   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>89</b> YRS.   |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  |  | IF UNDER 24 HRS.<br>HOURS MIN.                      |  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |  |  |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>KESWICK NURSING HOME</b> |  |  |   |  |  |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>                                       |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b> |  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  |  | 13b. COUNTY<br><b>BALTIMORE</b>  |  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>6701 PARK HTS. AVE. #21215</b>  |  |  |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>PHILIP GUNDERSHEIMER</b>   |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CARRIE BERGMAN</b>  |  |  |   |  |  |  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>220-46-2452</b>   |  |  | 17. INFORMANT<br><b>ESTATE OF MIRIAM G. JOFFEE</b>  |  |  | 10TH<br><b>20 S. CHARLES ST. BALTO., MD 21201</b>   |  |  | F.L.   |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Parkinson's Disease</b>   |  |  |  |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>21 yrs.</b>  |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)   |  |  |  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   |  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |  |  |  |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |  |  |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>14 July 81</b> to <b>27 Nov 84</b> , that (I) (we) last saw the deceased alive on <b>27 Nov 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Aubrey D. Richardson M.D.</b>  |  |  |  |  |  |   |  | DEGREE<br><b>MD</b>  |   |  |  | 22c. DATE SIGNED<br><b>27 Nov 1984</b>   |  |  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>AUBREY D. RICHARDSON, M.D.</b>  |  |  |  |  |  |   |  | 22e. ADDRESS<br><b>KESWICK NURSING HOME BALTO., MD 21211</b>                   |   |  |  |  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>  |  |  |  | 23b. DATE<br><b>NOV. 28, 1984</b>                                      |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE HEBREW</b>                  |   |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>  |  |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b>   |  |  |  |  |  |   |  | ADDRESS<br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>                       |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 3 1984</b>   |  |  |   |  |  |
|   |  |  |  |  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Richardson</b>                             |   |  |  |  |  |  |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



101 B

RECEIVED  
JAN 10 1964  
U.S. AIR FORCE  
OFFICE OF THE SECRETARY  
WASHINGTON, D.C.

TO: THE SECRETARY  
FROM: THE SECRETARY  
SUBJECT: [illegible]

1. [illegible]  
2. [illegible]  
3. [illegible]

4. [illegible]  
5. [illegible]  
6. [illegible]

7. [illegible]  
8. [illegible]  
9. [illegible]

10. [illegible]  
11. [illegible]  
12. [illegible]

206

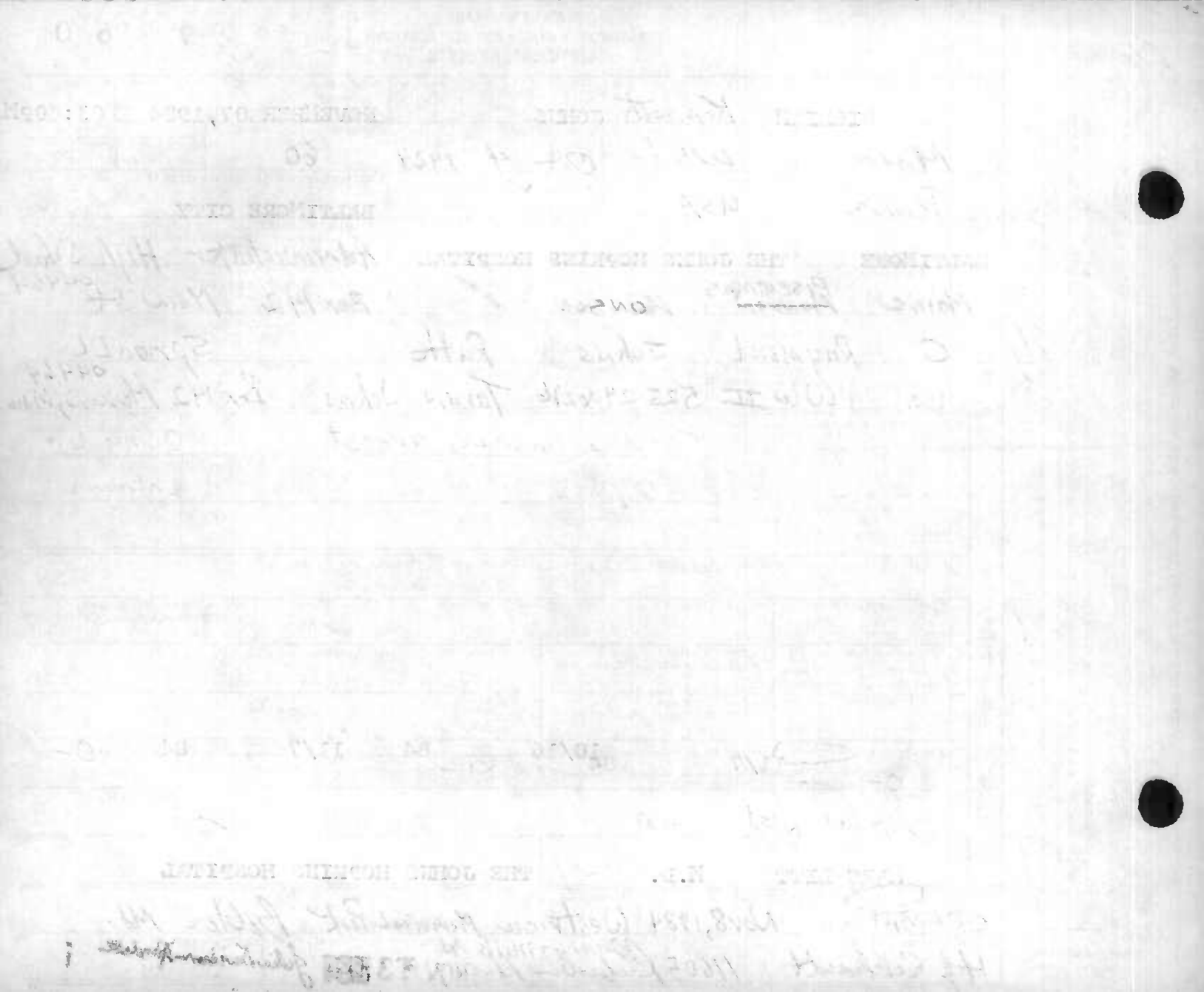
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
1- STATE  
REGISTRAR

REG. NO.

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>WILLIAM Kenneth JOHNS</b>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>NOVEMBER 07, 1984</b>                             |  | 2b. HOUR<br><b>03:40PM</b>   |
| 3 SEX<br><b>MALE</b>   | 4 RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct 4 1924</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>60</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Penna</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                        |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Administrator</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>High School</b>  |
| 13a. STATE<br><b>Maine</b>   | 13b. CITY OR TOWN<br><b>Monson</b>   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 13e. STREET ADDRESS / ZIP CODE<br><b>Box 142 Main St 04464</b>                           |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>C Raymond Johns</b>   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ruth Spruill</b>   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>yes</b>   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II 523-24-6294</b>  | 17. INFORMANT<br><b>Taran Johns</b>   |  | ADDRESS<br><b>Box 142 Monson, Maine 04464</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b>   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>20 minutes</b>  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>sepsis</b>  |  |   |  |  | <b>unknown</b>   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>10/16</b> , 19 <b>84</b> , to <b>11/7</b> , 19 <b>84</b> , that (1) <b>last</b> lost saw the deceased alive on <b>11/7</b> , 19 <b>84</b> , and that in my <b>(last)</b> opinion death occurred on the date and hour and from the causes stated above. (If I did not see the body after death) |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Marc Litt M.D.</b>  |  | DEGREE  |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARC LITT M.D.</b>   |  | 22e. ADDRESS<br><b>THE JOHNS HOPKINS HOSPITAL</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>CREMATION</b>   |  | 23b. DATE<br><b>Nov 8, 1984</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Memorial Park</b>                  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>  |  | 23e. DATE REC'D. BY REGISTRAR<br><b>NOV 13 1984</b>   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>H. Eckhardt</b>   |  | 24b. ADDRESS<br><b>11605 Rindge Rd. Baltimore, Md.</b>  |  |  |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |                              |  |  |  |  |  |   |  |  |  |  |  |
|--|--|------------------------------|--|--|--|--|--|---|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 3 4 2 9 9 6 1                |  | REG. NO.   |  |  |  |   |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |                              |  | 2a. DATE OF DEATH  |  | MONTH  |  | DAY   |  | YEAR   |  | 2b. HOUR   |  |
| Baby Box Johnson   |  |                              |  | 10   |  | 3  |  | 84  |  |  |  | 3 P.M.   |  |
| 3. SEX   |  | 4. RACE                      |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS.   |  |  |  |
| MALE   |  | BLACK                        |  | MONTH DAY YEAR<br>10 3 84  |  | YRS.   |  | MONTHS DAYS   |  | HOURS MIN.   |  | 1 20   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |  |  |  |  |
| MARYLAND   |  | U.S.A.                       |  |  |  | BALTIMORE CITY MD.   |  |   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                      |  |
| BALTIMORE  |  |                              |  | SINAI HOSPITAL   |  |  |  |   |  |  |  |  |  |
| 13a. STATE   |  |                              |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE   |  |  |  |
|  |  |                              |  |  |  |  |  |   |  | 99999  |  |  |  |
| 14. FATHER'S NAME  |  |                              |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |   |  |  |  |  |  |
| FIRST MIDDLE LAST<br>Lloyd JOHNSON   |  |                              |  | FIRST MIDDLE LAST<br>VANESSA   |  |  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |                              |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  |   |  | ADDRESS  |  |  |  |
|  |  |                              |  |  |  |  |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u>  |  |                              |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1' 20" |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>ACUTE Respiratory Failure</u>   |  |                              |  |  |  |  |  |   |  |  |  | Immediate  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>EXTREME PRIMARIETY</u>  |  |                              |  |  |  |  |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Chorioamnionitis</u>   |  |                              |  |  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
|  |  |                              |  |  |  |  |  |   |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |  |  |  |
|  |  |                              |  |  |  |  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                              |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |  |  |  |  |
|  |  |                              |  |  |  |  |  |   |  |  |  |  |  |
| 22a. I certify that (1) this hospital attended the deceased from <u>10/3</u> 19 <u>84</u> to <u>10/3</u> 19 <u>84</u> , that (1) he lost <u>10/3</u> 19 <u>84</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) was (were) (did not) view the body after death. |  |                              |  |  |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE   |  |                              |  | 22c. DATE SIGNED   |  |  |  |   |  |  |  |  |  |
| <u>Jacob K. Felix</u>  |  |                              |  | <u>10-3-84</u>   |  |  |  |   |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |                              |  | 22e. ADDRESS   |  |  |  |   |  |  |  |  |  |
| <u>Jacob K. Felix</u>  |  |                              |  | <u>Sinai Hospital</u>  |  |  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |                              |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| <u>CREMATION</u>   |  |                              |  | <u>10-7-84</u>   |  | <u>Sinai Hospital</u>  |  | <u>Baltimore Md. 21215</u>  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  |                              |  | 25a. DATE REC'D. BY REGISTRAR  |  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |  |
| <u>Sinai Hospital</u>  |  |                              |  | <u>NOV 14 1984</u>   |  |  |  | <u>Julia Davidson-Randall</u>   |  |  |  |  |  |

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |                                   |  |  |  |
|--|--|---|--|---|--|---|-----------------------------------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>BEATRICE JOHNSON</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 02 84</b> |   |  | 2b. HOUR<br><b>430 p.m.</b>   |                                   |  |  |  |
| 3. SEX<br><b>F</b>   |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 - 22 - 1909</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>(75) 75</b> YRS.                    |                                   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Deleware</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b> MD.              |                                   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIV OF MD. CANCER CENTER</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)          |                                   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |   |  |   | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>BALTO</b> |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Henry Johnson</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Estelle Harris</b> |   |                                   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT<br>ADDRESS<br><b>Betty Lane 2310 Lexington St. 21223</b>  |  |   |                                   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>uterine Sarcoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 year</b> |  |   |  |   |  |   |                                   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |   |  |   |  |   |                                   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |                                   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |                                   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/22</b> , 19 <b>84</b> , to <b>11/2</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>11/2</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |                                   |  |  |  |
| 22b. SIGNATURE<br><b>Richard Nora</b>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |   |                                   | 22c. DATE SIGNED<br><b>11/2/84</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RICHARD NORA</b>   |  |   |  | 22e. ADDRESS<br><b>UNIV OF MD CANCER CENTER</b>   |  |   |                                   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11-6-1984</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Memorial Park</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>   |                                   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Vernon R. Bailey</b>  |  |   |  | ADDRESS<br><b>1348 N. Calhoun Street</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 7 1984</b>                        |                                   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randell</b>  |  |  |

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |  |   |   |
|---|--|--|--|---|---|
| DECEASED NAME<br>(FIRST, MIDDLE, LAST)<br><b>JESSE R. Johnson</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 21 84</b> |   | 2b. HOUR<br>MIN.<br><b>10:00 P.M.</b>             |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 22 15</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>W. VA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO CITY</b>   |  | MD.  |  |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SBCH</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>  |   |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>J.S. Young</b>  |  |  |  |   |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b> |  | 13b. COUNTY<br><b>BALTO</b>  |  | 13c. CITY OR TOWN<br><b>BALTO</b>   |   |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                         |  | 13e. STREET ADDRESS<br><b>BALTO, MD, 21230</b>   |  |   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>TAYLOR R. Johnson</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>BESSIE P. HILKEY</b>   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>                                      |  | 16b. SOCIAL SECURITY NO.<br>(IF GIVEN IN WAR OR DATES)<br><b>W.W.2 35-14-1589</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Birdie Johnson, Same as above</b>   |   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**CARDIAC ARREST**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

**PULMONARY EMBOLISM**

DUE TO, OR AS A CONSEQUENCE OF

(c)

**RIGHT HIP FRACTURE**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

**COPD, CARDIAC ARYTHMIA**

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 19a. DATE OF OPERATION<br><b>11-10-84</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>FRACTURE Right HIP</b>         |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                  |  |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br>(OR CONTRIBUTING CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER))<br><input type="checkbox"/> CAUSE OF DEATH   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>5 A.M. 11/4/84</b>              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>fell at home</b> |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>home</b> |  | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>1210 Riverside Avenue, Baltimore City, MD</b>        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-4-84</b> to <b>11-21-84</b> , that (I) (we) lost<br>saw the deceased above on <b>11-21-84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (and) (did not) view the body after death. |  |   |  |   |  |
| 22b. SIGNATURE<br><b>R. Arguilla</b>   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>11-21-84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Lino R. Arguilla MD</b>  |  | 22e. ADDRESS<br><b>SBCH</b>   |  |   |  |

|  |  |                                   |  |  |  |   |  |
|--|--|-----------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                    |  | 23b. DATE<br><b>Nov. 26, 1984</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Len Haven Mem. Park</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glenn Burnie, A.A. Co. Md.</b> |  |
| 24. FUNERAL DIRECTOR<br><b>McCutty Funeral Home, 130 E. Fort Ave. Balto. Md.</b> |  |                                   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 23 1984</b>              |  |   |  |
|  |  |                                   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson</b>               |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |   |  |   |  |   |  |
|--|--|--|--|---|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Lloyd Winfield Johnson</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 25 1984</b>               |   |   | 2b. HOUR<br>M<br><b>M</b>  |   |  |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 18 1931</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS<br><b>52</b>                                  |   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4411 W. Forest Park Avenue</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Teacher</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Baltimore City Schools</b>   |   |  |
| 13a. STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>4411 W. Forest Pk. Ave, Balto. Md. 21207</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Shedrick P. Johnson</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rosella King</b>  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>218-28-6351</b>                         |   | 17. INFORMANT<br><b>Margaret Johnson</b>                                      |  |   |  | 4411 W. Forest Park Avenue<br>Baltimore, Maryland 21207                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>multiple myeloma</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>none</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>none</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 years &amp; 8 mos</b>   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><b>amyloidosis</b>   |  |  |  |   |   |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>none</b>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>none</b>        |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>           |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/16</b> 19 <b>79</b> to <b>11/15</b> 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>11/15</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Richard L. Humphrey</b>   |  |  |  |   | DEGREE<br><b>MD</b>   |  |   | 22c. DATE SIGNED<br><b>11/27/84</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Richard L. Humphrey</b>  |  |  |  |   | ADDRESS<br><b>Johns Hopkins Oncology Center</b>                               |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Entombment</b>   |  |  | 23b. DATE<br><b>11/30/1984</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Memorial Park</b>            |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                        |  |   |  |
| 24. FUNERAL HOME TO WHICH REMOVED<br>NAME ADDRESS<br><b>Nutter &amp; Sons 2501 Gwynns Falls Parkway</b><br><b>Funeral Home Inc. Baltimore, Maryland 21216</b>  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 30 1984</b>                           |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |  |

CHIEF OF POLICE

RECEIVED

| NAME          | ADDRESS                   | DATE       | REMARKS |
|---------------|---------------------------|------------|---------|
| W. J. Johnson | 111 W. Forest Park Avenue | 10 18 1931 |         |
| W. J. Johnson | 111 W. Forest Park Avenue | 10 18 1931 |         |
| W. J. Johnson | 111 W. Forest Park Avenue | 10 18 1931 |         |
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| W. J. Johnson | 111 W. Forest Park Avenue | 10 18 1931 |         |
| W. J. Johnson | 111 W. Forest Park Avenue | 10 18 1931 |         |

RECEIVED  
CHIEF OF POLICE  
11/17/31  
111 W. Forest Park Avenue  
Baltimore, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   | REG. NO.                               |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Martha V. Johnson   |  |   |  |   | 2a. DATE OF DEATH<br>November 29, 1984 |   |  | 2b. HOUR<br>M  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH<br>2 18 38   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>46 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>130 Aisquith St. Apt. 9F |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>MD  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>130 Aisquith St. Apt. 9F 21202   |  |
| 14. FATHER'S NAME<br>Robert Wellons   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>Corrine Butler  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>218-36-2204   |  | 17. INFORMANT<br>Celestine Cook   |  | ADDRESS<br>Apt. 7C<br>131 N. Aisquith St.   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cervical Cancer, metastatic</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cervical Cancer, IB</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.  |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Neil O. Rosenstein</u>   |  |   |  | 22c. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Neil O. Rosenstein</u>  |  |   |  | 22d. ADDRESS<br><u>The Johns Hopkins Hospital</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>12/4/84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Eastview Mem. Pk.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore MD                                      |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H 1101 E. North Ave.   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 4 1984   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Jane Davidson-Randall</u>                                      |  |  |  |

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JAN 10 1961



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. STATE REGISTRAR

|   |  |   |                                      |   |  |
|---|--|---|--------------------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | 2a. DATE OF DEATH   |                                      | 2b. HOUR  |  |
| NEWTON I. JOHNSON   |  | November 21   |                                      | 8:15a m   |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)      | IF UNDER 1 YEAR   |  |
| Male  | White  | MONTH DAY YEAR<br>7 5 18  | 66 YRS.                              | MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH |   |  |
| Virginia  | USA  |   | BALTIMORE CITY MD.                   |   |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   | 12b. KIND OF BUSINESS OR INDUSTRY    |   |  |
| BALTIMORE   | VA MEDICAL CENTER BALTIMORE MD   | Salesman  | Insurance                            |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS / ZIP CODE       |   |  |
| 13a. STATE  | 13b. COUNTY  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 4 Upland Road 21210                  |   |  |
| Md.   |  |   |                                      |   |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |                                      |   |  |
| FIRST MIDDLE LAST   |  | FIRST MIDDLE LAST   |                                      |   |  |
| Dolly Johnson   |  | Elizabeth Harwood   |                                      |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |                                      | 17. INFORMANT ADDRESS   |  |
| yes   |  | WW2 219 07 0060   |                                      | Mrs. Arline Johnson, Baltimore, Md.   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>HEAD + NECK CANCER</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |   |                                      |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |   |                                      |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                      | 20a. AUTOPSY?   |  |
|   |  |   |                                      | YES <input type="checkbox"/> NO <input type="checkbox"/>                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Nov. 17, 1984</u> , to <u>Nov. 21, 1984</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Nov. 21, 1984</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (did not) view the body after death. |  |   |                                      |   |  |
| 22b. SIGNATURE  |  | DEGREE  |                                      | 22c. DATE SIGNED  |  |
| <u>Bolzano</u>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                             |                                      |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |                                      |   |  |
| BOLZANO   |  | 3900 Loch Raven Blvd. Balto. Md 21218   |                                      |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE   |                                      | 23c. NAME OF CEMETERY OR CREMATORY  |  |
| Cremation   |  | 11-24-84  |                                      | Carroll Cremation   |  |
| 24. FUNERAL DIRECTOR NAME   |  | 24b. ADDRESS  |                                      | 25a. DATE REC'D. BY REGISTRAR   |  |
| Eline Funeral Home,   |  | Hampstead, Md.  |                                      | NOV 26 1984   |  |
|   |  |   |                                      | 25b. REGISTRAR'S SIGNATURE  |  |
|   |  |   |                                      | <u>Julia Davidson-Randall</u>   |  |

MEDICAL CERTIFICATION

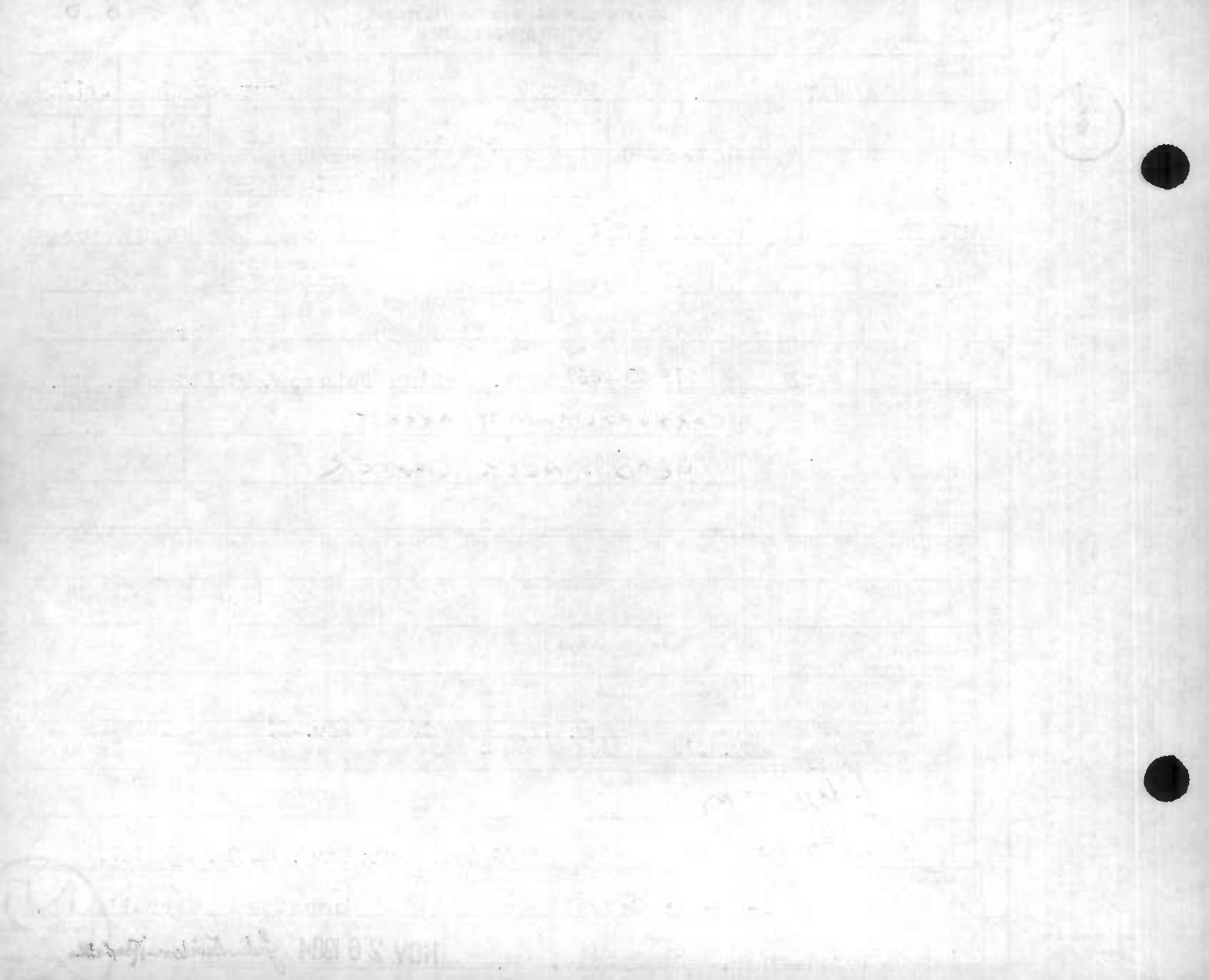
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove contents of pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examination must be certified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |   |   |   | REG. NO.  |  |
|---|---|---|---|---|--|
| 1. FOR STATE REGISTRAR  |   |   |   | 74 29967  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Theodore H. Johnson</b>  |   |   | 2a. DATE OF DEATH   |   | 2b. HOUR   |
|   |   |   | MONTH DAY YEAR  |   | 2b. HOUR   |
|   |   |   | 11 28 84  |   | 0755 AM  |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>BLACK</b>                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 27 04</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.                 |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD. |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MASON F. LORD CHRONIC HOSP.</b>             |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>GROOM (RACETRACK)</b>    |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD.</b>  |   | 13b. COUNTY<br><b>BALTIMORE</b>   | 13c. CITY OR TOWN<br><b>TIMONIUM</b>                              | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>619 W. SEMINARY AVE.</b>   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>FLETCHER JOHNSON</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Beatrice JOHNSON</b>  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>214-16-8835</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Beatrice Johnson 619 W. SEMINARY AVE.</b>                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia</b>   |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>24-48 hrs.</b>  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Unresponsiveness, inability to clear secretions</b>  |   |   |   |   | <b>2 months</b>  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Bilateral cerebrovascular accidents</b>  |   |   |   |   | <b>2 months</b>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>  |   |   |   |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/15</b> , 19 <b>84</b> , to <b>11/28</b> , 19 <b>84</b> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>11/27</b> , 19 <b>84</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did) (did not) view the body after death. |   |   |   |   |  |
| 22b. SIGNATURE<br><b>William M. Simpson, Jr.</b>  |   | DEGREE<br><b>MD.</b>  |   | 22c. DATE SIGNED<br><b>11/28/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>William M. Simpson, Jr.</b>   |   | 22e. ADDRESS<br><b>Mason F. Lord Chronic Hosp. 5200 Eastern Ave.</b>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   | 23b. DATE<br><b>12-1-84</b>                   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Memorial</b>  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>TIMONIUM MD</b>  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Chatman-HARRIS E H</b>   |   | ADDRESS<br><b>1701 McCulloch</b>  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 30 1984</b>               | 25b. REGISTRAR'S SIGNATURE<br><b>Davidson-Randall</b>   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>UNA MARIE JOHNSON   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 22, 1984  |  | 2b. HOUR<br>M  |
| 3. SEX<br>Female   | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept 22 1910  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.                                     | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                     |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Home - 4129 Hague Ave. |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Sales Clerk                 |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Package Goods   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   |   |   |  |  |
| 13a. STATE<br>Md.  | 13b. COUNTY<br>===  | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br>4129 Hague Ave. 21225                        |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Doc Valentine Hatfield   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Grace Corder   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>216-01-8478  |   | 17. INFORMANT ADDRESS<br>Samuel G. Johnson Jr. same as 13 e                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Probable Acute Myocardial Infarction<br>DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease 1980<br>DUE TO, OR AS A CONSEQUENCE OF (c)                     |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Few hours  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 60 to Present 19, that (I) (we) lost saw the deceased alive on 11/14 19 82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |   |  |  |
| 22b. SIGNATURE<br>Colvin C Carter MD   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   | 22c. DATE SIGNED<br>11/23/84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Colvin C Carter, MD   |   | 22e. ADDRESS<br>4700 Pennington Ave Baltimore.  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |   | 23b. DATE<br>11/26/84   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Mem Pk                        |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Glen Burnie A.A. Md.   |   | 23e. DATE REC'D. BY REGISTRAR<br>NOV 27 1984  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>George J. Gonce  |   | 24b. ADDRESS<br>4001 Ritchie Hgwy   |   | 24c. REGISTRAR'S SIGNATURE<br>Davidson-Rodella                                 |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 and 2 should be filed within 72 hours after death. Page 3 should be filed within 72 hours after death. Page 4 should be filed within 72 hours after death. Page 5 should be filed within 72 hours after death. Page 6 should be filed within 72 hours after death. Page 7 should be filed within 72 hours after death. Page 8 should be filed within 72 hours after death. Page 9 should be filed within 72 hours after death. Page 10 should be filed within 72 hours after death. Page 11 should be filed within 72 hours after death. Page 12 should be filed within 72 hours after death. Page 13 should be filed within 72 hours after death. Page 14 should be filed within 72 hours after death. Page 15 should be filed within 72 hours after death. Page 16 should be filed within 72 hours after death. Page 17 should be filed within 72 hours after death. Page 18 should be filed within 72 hours after death. Page 19 should be filed within 72 hours after death. Page 20 should be filed within 72 hours after death. Page 21 should be filed within 72 hours after death. Page 22 should be filed within 72 hours after death. Page 23 should be filed within 72 hours after death. Page 24 should be filed within 72 hours after death. Page 25 should be filed within 72 hours after death. Page 26 should be filed within 72 hours after death. Page 27 should be filed within 72 hours after death. Page 28 should be filed within 72 hours after death. Page 29 should be filed within 72 hours after death. Page 30 should be filed within 72 hours after death. Page 31 should be filed within 72 hours after death. Page 32 should be filed within 72 hours after death. Page 33 should be filed within 72 hours after death. Page 34 should be filed within 72 hours after death. Page 35 should be filed within 72 hours after death. Page 36 should be filed within 72 hours after death. Page 37 should be filed within 72 hours after death. Page 38 should be filed within 72 hours after death. Page 39 should be filed within 72 hours after death. Page 40 should be filed within 72 hours after death. Page 41 should be filed within 72 hours after death. Page 42 should be filed within 72 hours after death. Page 43 should be filed within 72 hours after death. Page 44 should be filed within 72 hours after death. Page 45 should be filed within 72 hours after death. Page 46 should be filed within 72 hours after death. Page 47 should be filed within 72 hours after death. Page 48 should be filed within 72 hours after death. Page 49 should be filed within 72 hours after death. Page 50 should be filed within 72 hours after death. Page 51 should be filed within 72 hours after death. Page 52 should be filed within 72 hours after death. Page 53 should be filed within 72 hours after death. Page 54 should be filed within 72 hours after death. Page 55 should be filed within 72 hours after death. Page 56 should be filed within 72 hours after death. Page 57 should be filed within 72 hours after death. Page 58 should be filed within 72 hours after death. Page 59 should be filed within 72 hours after death. Page 60 should be filed within 72 hours after death. Page 61 should be filed within 72 hours after death. Page 62 should be filed within 72 hours after death. Page 63 should be filed within 72 hours after death. Page 64 should be filed within 72 hours after death. Page 65 should be filed within 72 hours after death. Page 66 should be filed within 72 hours after death. Page 67 should be filed within 72 hours after death. Page 68 should be filed within 72 hours after death. Page 69 should be filed within 72 hours after death. Page 70 should be filed within 72 hours after death. Page 71 should be filed within 72 hours after death. Page 72 should be filed within 72 hours after death. Page 73 should be filed within 72 hours after death. Page 74 should be filed within 72 hours after death. Page 75 should be filed within 72 hours after death. Page 76 should be filed within 72 hours after death. Page 77 should be filed within 72 hours after death. Page 78 should be filed within 72 hours after death. Page 79 should be filed within 72 hours after death. Page 80 should be filed within 72 hours after death. Page 81 should be filed within 72 hours after death. Page 82 should be filed within 72 hours after death. Page 83 should be filed within 72 hours after death. Page 84 should be filed within 72 hours after death. Page 85 should be filed within 72 hours after death. Page 86 should be filed within 72 hours after death. Page 87 should be filed within 72 hours after death. Page 88 should be filed within 72 hours after death. Page 89 should be filed within 72 hours after death. Page 90 should be filed within 72 hours after death. Page 91 should be filed within 72 hours after death. Page 92 should be filed within 72 hours after death. Page 93 should be filed within 72 hours after death. Page 94 should be filed within 72 hours after death. Page 95 should be filed within 72 hours after death. Page 96 should be filed within 72 hours after death. Page 97 should be filed within 72 hours after death. Page 98 should be filed within 72 hours after death. Page 99 should be filed within 72 hours after death. Page 100 should be filed within 72 hours after death.

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**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

29969

|  |                         |   |   |   |                                |   |   |  |
|--|-------------------------|---|---|---|--------------------------------|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Carpenter B. Jones</b>   |                         |   | 2a. DATE OF DEATH<br>KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>11/17/84</b> |   |                                | 2b. HOUR<br><b>11:55</b>  |   |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Black</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 3 05</b>   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>79</b> YRS.  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS.<br>HOURS MIN. | 2c. DATE PRONOUNCED DEAD<br><b>11/17/84</b>   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>                                   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>714 E. 20th Street</b> |   |   |                                | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |   | 12b. KIND OF BUSINESS OR INDUSTRY            |
| 13a. STATE<br><b>MD</b>  |                         | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |                                | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 13e. STREET ADDRESS<br><b>714 E. 20th St.</b>  |                         | 13f. ZIP CODE<br><b>21218</b>   |   |   |                                |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Noah Jones</b>  |                         |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |                                |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |                         | 16b. SOCIAL SECURITY NO.<br><b>218-10-5648</b>  |   | 17. INFORMANT<br>NAME ADDRESS<br><b>Mary Jones 3322 1/2 Woodland Ave.</b>   |                                |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |                         |   |   |   |                                |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |                         |   |   |   |                                |   |   |  |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |   |                                |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                                |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                |   |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |   |   |   |                                |   |   |  |
| ACTUAL SIGNATURE<br><i>Margarita A. Korell</i>   |                         | TITLE (SPECIFY)<br>M.D. <b>Assistant</b> MEDICAL EXAMINER   |   |   |                                |   | DATE SIGNED <b>11/18/84</b>   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Margarita A. Korell, M.D.</b>   |                         | ADDRESS<br><b>111 Penn St.</b>  |   |   |                                |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |                         | 23b. DATE<br><b>11/24/84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Church Com.</b>  |                                |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Eastern Shore MD</b>               |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Ave.</b>   |                         |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 19 1984</b>   |                                | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>                                     |   |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP  
DHMH - 17  
(VR A15 ME (5))



NOV 19 1904



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                  |   |  |   |  |  |  |   |  | REG. NO. 29970   |  |
|---|------------------|---|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>GEORGE W. JONES JR.   |                  |   |  |   |  |  |  |   |  | 2a. DATE KNOWN OF DEATH ESTI-MATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>11 22 19 84 |  |
| 3. SEX<br>Male  | 4. RACE<br>Black | 5. DATE OF BIRTH MONTH DAY YEAR<br>2 27 47  | 6. AGE (IN YEARS) (LAST BIRTHDAY) YRS.<br>37 | 7. IF UNDER 1 YR. MONTHS DAYS   | 7. IF UNDER 24 HRS. HOURS MIN.                               | 2c. DATE PRONOUNCED DEAD<br>11 22 19 84  |  | 2d. HOUR<br>8:04 a.m.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD   |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hosp. (STU) |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. STATE<br>MD  |                  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>5426 Jonquil Ave. 21215                                      |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>George W. Jones Sr.  |                  |   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Eleanor Howard |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>Yes   |                  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>214-68-1633   |  | 17. INFORMANT ADDRESS<br>Yvonne Jones 37 Albemarle St.  |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Shotgun wound of abdomen with complications</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH       |                  |   |  |   |  |  |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1  |                  |   |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                  | 21b. TIME OF INJURY HOUR MIN. MONTH DAY YEAR<br>9:50 P.M. 10-31- 19 84  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Subject shot.  |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>cab  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br>2700 blk. Claflin Ct., Balto. City Md.  |  |  |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                  |   |  |   |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE  |                  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER  |  |   |  | DATE SIGNED 11-23-84   |  |   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Ann M. Dixon, M.D.   |                  | ADDRESS 111 Penn St., Balto., Md. 21201   |  |   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |                  | 23b. DATE<br>11/29/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Eastview Mem. Pk.   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore MD                                      |  |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br>Wm. C. March F/H 1101 E. North Ave.  |                  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 28 1984  |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Rendell   |  |   |  |  |  |

QND

REPT. NOTED % 0.0

WINTER



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |   |                                   |   |
|---|--|---|--|---|--|--|---|-----------------------------------|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST MIDDLE LAST   |  | 2a. DATE OF DEATH   |  | MONTH DAY YEAR   |   | 2b. HOUR                          |   |
| HATTIE  |  | JONES   |  | NOVEMBER 11, 1984   |  | 8:31pM   |   |                                   |   |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                  |   | IF UNDER 1 YEAR                   |   |
| Female  |  | Black   |  | MONTH DAY YEAR<br>8 25 91   |  | 93   |   | MONTHS DAYS HOURS MIN.            |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                             |   |                                   |   |
| North Carolina  |  | USA   |  |   |  | Baltimore City MD  |   |                                   |   |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY |   |
| Baltimore   |  | Maryland General Hospital   |  |   |  |  |   |                                   |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  | 13b. INSIDE CITY LIMITS?  |  | 13c. STREET ADDRESS / ZIP CODE                                   |   |                                   |   |
| 13a. STATE  |  |   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |   | 21201                             |   |
| Md.   |  |   |  | Balto.  |  | 607 Pennsylvania Ave.  |   |                                   |   |
| 14. FATHER'S NAME   |  |   |  | 15. MOTHER'S MAIDEN NAME  |  |  |   |                                   |   |
| FIRST MIDDLE LAST   |  |   |  | FIRST MIDDLE LAST   |  |  |   |                                   |   |
| Jessie  |  |   |  | Annie   |  | Howard   |   |                                   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  | ADDRESS  |   |                                   |   |
| No  |  | 215-28-9352   |  | D Louise Ward   |  | 2433 Edmondson Ave.  |   |                                   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of the Colon</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Aspiration Pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Congestive Heart Failure</u>                                     |  |   |  |   |  |  |   |                                   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>Congestive Heart Failure</u>   |  |   |  |   |  |  |   |                                   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |                                   |   |
|   |  |   |  |   | YES <input type="checkbox"/> NO <input type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>          |                                   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |   |                                   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |                                   |   |
| 22a. I certify that X (this hospital) attended the deceased from <u>October 23, 1984</u> to <u>November 11, 1984</u> that X (we) lost<br>saw the deceased alive on <u>November 11, 1984</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. X (we) did (XXX) view the body after death. |  |   |  |   |  |  |   |                                   |   |
| 22b. SIGNATURE  |  |   |  | DEGREE  |  | 22c. DATE SIGNED   |   |                                   |   |
| M. Kibane, M.D.   |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 11-12-84   |   |                                   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  | 22e. ADDRESS  |  |  |   |                                   |   |
| Mien-Poor Kibane  |  |   |  | c/o Maryland General Hospital   |  |  |   |                                   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                       |   |                                   |   |
| Burial  |  | 11-15-84  |  | Mt. Auburn Cem.   |  | Balto. Md.   |   |                                   |   |
| 24. FUNERAL DIRECTOR  |  |   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE                                       |   |                                   |   |
| NAME ADDRESS  |  |   |  |   |  |  |   |                                   |   |
| Wm. C. March F/H 1101 E. North Ave.   |  |   |  | NOV 13 1984   |  | Julia Davidson   |   |                                   |   |



UNCLASSIFIED



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 29972

1- FOR  
STATE  
REGISTRAR

|   |  |   |  |   |  |   |  |   |  |   |  |   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|---|--|---|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   |  | MIDDLE  |  | LAST  |  | 2a. DATE KNOWN<br>OF DEATH  |  | MONTH   |  | DAY   |  | YEAR  |  | 2b. HOUR  |  |   |  |
| IRVIN   |  |   |  |   |  | JONES   |  | 11 / 22, 84   |  |   |  |   |  |   |  | M   |  |   |  |
| 3. SEX<br>male  |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH<br>MONTH   |  | YEAR  |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)  |  | IF UNDER 1 YR.<br>MONTHS  |  | IF UNDER 24 HRS.<br>DAYS  |  | HOURS   |  | MIN   |  |   |  |
| 7a. BIRTHPLACE (STATE OR<br>COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  | 2c. DATE<br>PRONOUNCED<br>DEAD  |  | MONTH   |  | DAY   |  | YEAR  |  | 2d. HOUR  |  |   |  |
| Maryland  |  | U.S.A.  |  |   |  | Baltimore City  |  | 11 / 22, 84   |  |   |  |   |  |   |  | 4:35A   |  |   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY  |  | 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS   |  |   |  |
| Baltimore   |  | Rear/3000 Liberty Hgts Avenue   |  | student   |  |   |  | MD  |  |   |  | Baltimore   |  | YES   |  | 843 Mt. Holly St. 21229   |  |   |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  | ADDRESS   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Shot gun wound to back (Weapon: Shotgun)<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause lost.<br>(b) _____<br>(c) _____  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |   |  |   |  |
| Irvin Jones,  |  | Marylyn S. Thompson   |  |   |  | 217-86-9790   |  | Irvin Jones, Sr.  |  | 843 N. Mt. Holly  |  |   |  |   |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1  |  | 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE<br>AT WORK <input checked="" type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
|   |  |   |  |   |  |   |  | 4:30 PM 11/22 1984  |  | subject shot  |  |   |  | 3000 Liberty Hgts Ave (rear), Baltimore City, MD  |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | 22b. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | 22c. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | 22d. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | 22e. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | 22f. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | 22g. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | 22h. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | 22i. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | 22j. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |
| ACTUAL<br>SIGNATURE   |  | TITLE (SPECIFY)   |  | DATE  |  | 11/22/84  |  | 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |   |  |   |  |
| Gregory R. Kauffman, MD   |  | Assistant   |  | 11/22/84  |  |   |  | Burial  |  | 11-26-84  |  | Arbutus Memorial Park   |  | Arbutus Maryland  |  |   |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)  |  | ADDRESS   |  | 24. FUNERAL DIRECTOR<br>NAME  |  | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  | 25c. DATE REC'D. BY REGISTRAR   |  | 25d. REGISTRAR'S SIGNATURE  |  |   |  |   |  |
| Gregory R. Kauffman, MD   |  | 111 Penn Street, Baltimore, MD 21201  |  | Vernon R. Bailey  |  | 1348 N. Calhoun St.   |  | NOV 27 1984   |  | Julia Davidson-Rendell  |  |   |  |   |  |   |  |   |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE  
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.  
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.  
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS  
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,  
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

20% COTTON 100% WOOL

WINTER 1941



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

1 - STATE REGISTRAR

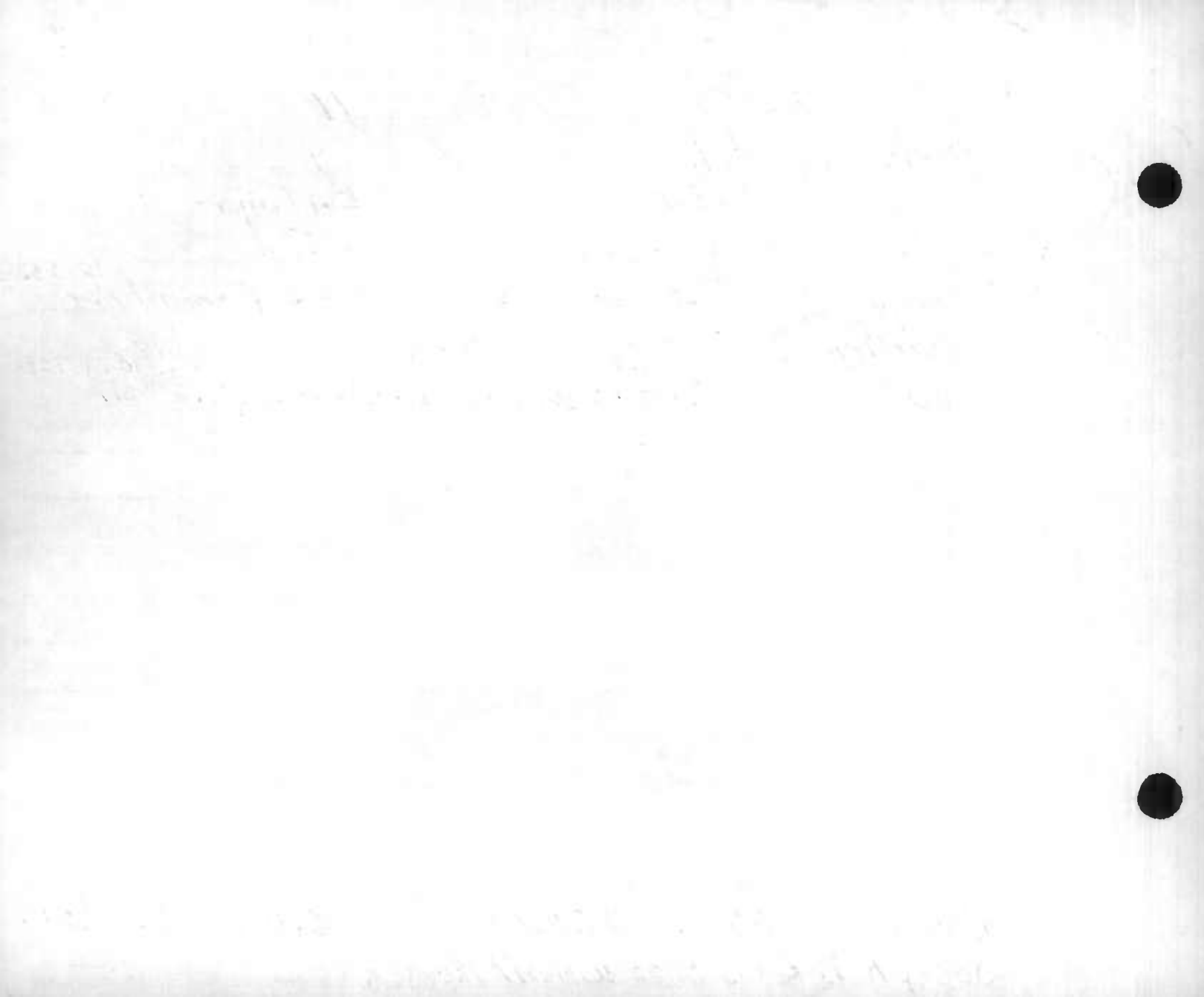
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |   |   |  |  |   |   |  |
|---|--|--|---|---|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Liston</b> FIRST <b>JONES</b> MIDDLE LAST  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>11-3-84</b>                     |   |  | 2b. HOUR <b>1054</b> M   |   |   |  |
| 3. SEX <b>male</b>  |  | 4. RACE <b>Col.</b>  |   | 5. DATE OF BIRTH MONTH DAY YEAR <b>1-28-10</b>  |  | 6. AGE (IF YEARS (LAST BIRTHDAY)) <b>74</b> YRS.                       |   | 7. UNDER 1 YEAR<br>MONTHS DAYS<br>8. UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S.C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.         |   |   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bon Secours Hosp</b> |   |   |  | 12a. USUAL OCCUPATION (TYPE OR MOST OF WORKING LIFE) <b>Retired</b>    |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. COUNTY <b>BALTO.</b>   |  |  |   | 13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13c. STREET ADDRESS / ZIP CODE <b>313 S Fremont Ave. 21230</b>         |   |   |  |
| 14. FATHER'S NAME FIRST <b>William</b> MIDDLE LAST <b>Jones</b>   |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST <b>NANDA</b> MIDDLE <b>Begy boy</b> LAST   |  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   |  | 16b. SOCIAL SECURITY NO. <b>249-34-276</b>   |   | 17. INFORMANT <b>Miss LAURIA Jones</b>  |  | ADDRESS <b>Phila. Pa. 19122</b><br><b>2016 N. 8th St.</b>              |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio Pulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>CH. pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>   |  |  |   |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:   |  |  |   |   |  |  |   |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>              |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |  |  |   |   |  |
| 22b. SIGNATURE <b>Kathleen [Signature]</b> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |  |   |   |  | 22c. DATE SIGNED <b>11/5/84</b>  |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |   |   | 22e. ADDRESS   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE) <b>BURIAL</b>  |  |  | 23b. DATE <b>11-7-84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cem.</b>                      |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. CO. MD.</b> |   |  |
| 24. FUNERAL DIRECTOR NAME <b>Joseph L. Russ</b> ADDRESS <b>2222 W. North Ave.</b>   |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR <b>NOV 5 1984</b>                                |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>                 |   |  |

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |                              |   |  |                                    |  |   |                 |  |  |  |
|--|--|------------------------------|---|--|------------------------------------|--|---|-----------------|--|--|--|
| 8 4 2 9 9 7 4  |  |                              |   |  |                                    |  |   |                 |  |  |  |
| 1- FOR STATE REGISTRAR   |  |                              |   |  |                                    |  |   |                 |  |  |  |
| CERTIFICATE OF DEATH   |  |                              |   |  |                                    |  |   |                 |  |  |  |
| REG. NO.   |  |                              |   |  |                                    |  |   |                 |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |                              | FIRST MIDDLE LAST   |  |                                    | 2a. DATE OF DEATH  |   | MONTH DAY YEAR  |  | 2b. HOUR                                     |  |
| Rhoda  |  |                              | Jones   |  |                                    | 11-1-84  |   | 4:17P.M.        |  |  |  |
| 3. SEX   |  | 4. RACE                      |   | 5. DATE OF BIRTH   |                                    | 6. AGE (IN YEARS LAST BIRTHDAY)  |   | IF UNDER 1 YEAR |  | IF UNDER 24 HRS                              |  |
| Female   |  | Black                        |   | 1 20 06  |                                    | 78   |   | MONTHS DAYS     |  | HOURS MIN.                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY? |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH   |   |                 |  |  |  |
| MD   |  | USA                          |   |  |                                    | Baltimore City MD.   |   |                 |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION             |  |                                    |  |   |                 |  |  |  |
| Baltimore  |  |                              | Lutheran Hospital   |  |                                    |  |   |                 |  |  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |                              | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                                    |  |   |                 |  |  |  |
|  |  |                              |   |  |                                    |  |   |                 |  |  |  |
| 13a. STATE   |  |                              | 13b. COUNTY   |  | 13c. CITY OR TOWN                  |  | 13d. INSIDE CITY LIMITS?  |                 | 13e. STREET ADDRESS  |  |  |
| MD   |  |                              |   |  | Baltimore                          |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                 | 811 N. Payson St. 21217  |  |  |
| 14. FATHER'S NAME  |  |                              |   |  | 15. MOTHER'S MAIDEN NAME           |  |   |                 |  |  |  |
| FIRST MIDDLE LAST  |  |                              |   |  | FIRST MIDDLE LAST                  |  |   |                 |  |  |  |
| Clarence Dorsey  |  |                              |   |  | Edith Hance                        |  |   |                 |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |                              |   |  | 16b. SOCIAL SECURITY NO.           |  | 17. INFORMANT ADDRESS   |                 |  |  |  |
| No   |  |                              |   |  | 215-14-3725                        |  | Edith Mickles 811 N. Payson St.                                     |                 |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |                              |   |  |                                    |  |   |                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:   |  |                              |   |  |                                    |  |   |                 |  |  |  |
| IMMEDIATE CAUSE (a) Sepsis   |  |                              |   |  |                                    |  |   |                 |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |                              |   |  |                                    |  |   |                 |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |                              |   |  |                                    |  |   |                 |  |  |  |
| (b)  |  |                              |   |  |                                    |  |   |                 |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |                              |   |  |                                    |  |   |                 |  |  |  |
| (c)  |  |                              |   |  |                                    |  |   |                 |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |                              |   |  |                                    |  |   |                 |  |  |  |
| cerebrovascular accident   |  |                              |   |  |                                    |  |   |                 |  |  |  |
| 19a. DATE OF OPERATION   |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |                                    |  | 20a. AUTOPSY?   |                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |
|  |  |                              |   |  |                                    |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                 | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                              | 21b. TIME OF INJURY   |  |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) |   |                 |  |  |  |
|  |  |                              | HOUR A.M. MONTH DAY YEAR  |  |                                    |  |   |                 |  |  |  |
|  |  |                              | P.M. 19   |  |                                    |  |   |                 |  |  |  |
| 21d. INJURY OCCURRED   |  |                              | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |                                    | 21f. LOCATION  |   |                 |  |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                              |   |  |                                    | STREET CITY OR TOWN COUNTY STATE   |   |                 |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-28 1984 to 11-1-1984, that (I) (we) lost saw the deceased alive on 11-1-1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                              |   |  |                                    |  |   |                 |  |  |  |
| 22b. SIGNATURE   |  |                              |   |  | DEGREE                             |  |   |                 |  | 22c. DATE SIGNED                             |  |
| Matthew  |  |                              |   |  |                                    |  |   |                 |  | 11-1-84                                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |                              |   |  | 22e. ADDRESS                       |  |   |                 |  |  |  |
| A. Mathew  |  |                              |   |  | 730 Ashburton St. Baltimore        |  |   |                 |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |                              | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY |  |   | 23d. LOCATION   |  |  |  |
| Burial   |  |                              | 11/7/84   |  | Church Cem.                        |  |   | Kent Co. MD     |  |  |  |
| 24. FUNERAL DIRECTOR   |  |                              |   |  |                                    | 25a. DATE REC'D. BY REGISTRAR  |   |                 | 25b. REGISTRAR'S SIGNATURE                                     |  |  |
| NAME   |  |                              |   |  |                                    |  |   |                 |  |  |  |
| Wm. C. March F/H 1101 E. North Ave.  |  |                              |   |  |                                    | NOV 5 1984   |   |                 | Richardson-Randall   |  |  |

20% COTTON FIBRE

RELEASED AS NOW MED TO JHH BY DR ANN ON OF THE

TO HOSPITAL OR ATTENDING PHYSICIAN: The lower copy of this death certificate is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: A MEDICAL EXAMINER'S OFFICE should be detached for use as the burial transit permit. Then please remove carbon #3 and #4 and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |   |  | 8 4 2 9 9 7 5 |  |
|--|--|---|--|---|--|---|--|---|--|---------------|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO.  |  |   |  |   |  |   |  |               |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   |  | 2a. DATE OF DEATH   |  |   |  | 2b. HOUR  |  |               |  |
| FIRST MIDDLE LAST<br>ROBERT CODY JONES   |  |   |  | MONTH DAY YEAR<br>NOVEMBER 14, 1984   |  |   |  | 09:11AM   |  |               |  |
| 1. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7. IF UNDER 1 YEAR  |  |               |  |
| Male   |  | White   |  | MONTH DAY YEAR<br>July 27, 1984   |  | YRS 3   |  | DAYS 17   |  |               |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |   |  |               |  |
| Maryland   |  | U.S.  |  |   |  | BALTIMORE CITY MD.  |  |   |  |               |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |  | 12b. KIND OF BUSINESS OR INDUSTRY                                 |  |               |  |
| BALTIMORE  |  | THE JOHNS HOPKINS HOSPITAL  |  |   |  | -----   |  | -----   |  |               |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  | 13b. INSIDE CITY LIMITS?  |  | 13c. STREET ADDRESS / ZIP CODE                                      |  |   |  |               |  |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br>Maryland Baltimore Parkton   |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 19217 Spook Hill Rd./21120  |  |   |  |               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Robert W. Jones  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary M. Jardeleza  |  |   |  |   |  |               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT   |  | ADDRESS   |  |   |  |               |  |
| No   |  | None  |  | Robert W. Jones   |  | 19217 Spook Hill Rd.<br>Parkton, MD 21120                           |  |   |  |               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>15 min</u>  |  |               |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Cardiopulmonary arrest</u>  |  |   |  |   |  |   |  | <u>18 hrs.</u>  |  |               |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |   |  |   |  |   |  |   |  |               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)   |  |   |  |   |  |   |  |   |  |               |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |  |               |  |
|  |  |   |  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>          |  |               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 13</u> , 19 <u>84</u> , to <u>Nov 14</u> , 19 <u>84</u> , that (I) (we) lost<br>saw the deceased alive on <u>Nov 14</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |   |  |               |  |
| 22b. SIGNATURE<br><u>Deborah D. Bittar MD</u>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br><u>11/14/84</u>                               |  |               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Deborah G. Bittar MD</u>   |  |   |  | 22e. ADDRESS<br><u>Johns Hopkins Hospital</u>   |  |   |  |   |  |               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |   |  |               |  |
| Cremation  |  | Nov. 16, 1984   |  | Carroll Cremation Services  |  | Hampstead Carroll MD  |  |   |  |               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>J.J. Hartenstein, New Freedom, PA 17349  |  |   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTERED SIGNATURE   |  |   |  |               |  |
|  |  |   |  | NOV 23 1984   |  |   |  |   |  |               |  |



*[The page contains extremely faint, illegible text and markings, possibly bleed-through from the reverse side. No specific words or figures can be discerned.]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8-4 29976

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>WILLIAM WOOD JONES  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 1 84  |  | 2b. HOUR<br>12 <sup>34</sup> P.M.  |
| 3. SEX<br>Male   | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 21, 1920  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>64 YRS.  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>MD   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Chief Executive             | 12b. KIND OF BUSINESS OR INDUSTRY<br>Balto.  |  |
| 13a. STATE<br>MD   | 13b. COUNTY  | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>Stationery Co.<br>5105 Springlake Way, 21212                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Calvert R. Jones, Sr.  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Emma LeCompte Smith                            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes WW II  |  | 16b. SOCIAL SECURITY NO.<br>220 05 0431   | 17. INFORMANT<br>ADDRESS<br>Mrs. William W. Jones, Same   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of Prostate-glandular Metastasis - 10 Mors</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____   |  |   |   |  |  |
| 19a. DATE OF OPERATION<br>—  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>—   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)<br>—             |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>—   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>—  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>August 3, 1984</u> to <u>Novel 1, 1984</u> , that (I) (we) last saw the deceased alive on <u>November 1, 1984</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |  |  |
| 22b. SIGNATURE<br><u>W. Grafton Hersperger M.D.</u>  |  |   | DEGREE<br>M.D.  | 22c. DATE SIGNED<br>11/1/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>W. GRAFTON HERSPERGER, M.D.   |  |   | 22e. ADDRESS<br>214 MEDICAL ARTS BLDG. 21201  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   | 23b. DATE<br>11/5/84   | 23c. NAME OF CEMETERY OR CREMATORY<br>Old Trinity Church  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Church Creek                           |  |
| 24. FUNERAL DIRECTOR<br>NAME Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., MD 21212  |  |   | 25. DATE REC'D. BY REGISTRAR<br>11/1/84 REGISTRAR'S SIGNATURE                                   |  |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

11/15/64  
 Henry W. Jones & Son, Co.  
 1115 Broadway, New York 10038  
 11/15/64  
 1115 Broadway, New York 10038  
 11/15/64  
 1115 Broadway, New York 10038



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 1115 Broadway, New York 10038  
 11/15/64  
 1115 Broadway, New York 10038

Yes WW II \$20.00 0-81 Mr. William W. Jones, Jr.

Oliver, R. Jones, Sr. 1800 1st St. N.

MD Baltimore \* 1115 Springdale Way, 21212

Chief Executive Officer

USA

White

J.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner or his/her medical attendant should be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |  |  |   |  |
|---|--|---|--|--|--|--|--|---|--|
| 1- FOR STATE REGISTRAR  |  | REG. NO.  |  | 8 4 -2929977   |  |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  | 2a. DATE OF DEATH  |  |  |  | 2b. HOUR  |  |
| FIRST MIDDLE LAST<br>Thomas Albert Julius   |  |   |  | MONTH DAY YEAR<br>11 28 89   |  |  |  | 7:25 P M  |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 7. IF UNDER 1 YEAR  |  |
| Male  |  | Caucasian   |  | MONTH DAY YEAR<br>7 14 1900  |  | 84 YRS.  |  | IF UNDER 24 HRS.  |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |
| Maryland  |  | USA   |  |  |  | Baltimore City MD  |  |   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| Baltimore City  |  | South Baltimore General Hosp  |  |  |  | Retired Truck driver   |  | Chauffeur   |  |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS / ZIP CODE  |  |
| Maryland  |  | Anne Arundel  |  | Glen Burnie  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 118 Highland Road 21061   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |  |  |  |   |  |
| Thomas Julius   |  |   |  | Dorothy Hoffmann   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |  |   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  |   |  |
| no  |  |   |  | 220 096 078  |  | Hospital Record Dorothy Hoffmann 21061   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Congestive Heart failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Chronic Obstructive Pulmonary Disease</u> |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 hour<br>3 wks<br>many years |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (a)<br><u>Right Carotid Artery Aneurysm; Cardiac arrhythmia &amp; Pacemaker implanted in 1977</u>  |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?   |  |
|   |  |   |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (this hospital) attended the deceased from <u>11-28-89</u> to <u>11-28-89</u> , that (we) lost<br>saw the deceased alive on <u>11-28-89</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above, (we) (did not) view the body after death.         |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br>Raymond J. Felius   |  |   |  | DEGREE<br>MD   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>11-28-89  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Raymond J. Felius  |  |   |  | 22e. ADDRESS<br>50. Baltimore Gen. Hosp; 3001 S. Hanover St.   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |   |  |
| Burial  |  | 12/1/1984   |  | David Ridge Cemetery   |  | Baltimore, Maryland  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>McCully Funeral Homes   |  |   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |
| Balto., Md., 21225<br>237 E. Patapsco Ave.  |  |   |  | NOV 30 1984  |  | Davidson-Randall   |  |   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |  |   |   |
|--|---|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Gerald L. Juren</b>                                    |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11 06 84</b>                                |   | 2b. HOUR<br><b>1247p.m.</b>                   |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Caucasian</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>07 20 10</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS.                         | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.         |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hospital of Baltimore</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>—</b> |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b> |   |   | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Pikesville</b>        |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>LOUIS JUREN</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>EVA MANDEL</b>                 |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                  |   | 16b. SOCIAL SECURITY NO.<br><b>242-01-8227</b>  |  | 17. INFORMANT ADDRESS<br><b>Lee Tuchman 3309 Walnut Dr. Owings, Mills</b> |   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Acute MI**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost.

(b) **ASCVD**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHPART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: **diabetes, peripheral vasc. disease, renal insufficiency**

|  |  |  |  |  |   |
|--|--|--|--|--|---|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/6</b> , 19 <b>84</b> , to <b>11/6</b> , 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>11/6</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>before (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |
| 22b. SIGNATURE<br><b>Steven Grufferman MD</b>  |  |  |  | 22c. DATE SIGNED<br><b>11/6/84</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Steven Grufferman MD</b>   |  |  |  | 22e. ADDRESS<br><b>Sinai Hospital of Baltimore, Md.</b>                              |   |

|  |                             |  |  |
|--|-----------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>    | 23b. DATE<br><b>11/7/84</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Beth El Memorial Park</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Randallstown Balto. MD.</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Hebrew Memorial F.H., Inc</b> |                             | ADDRESS<br><b>1100 Reisterstown Rd Pikesville MD 21208</b>         | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 9 1984</b>                           |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |   |  |  |   |   |
|---|--|--|--|---|---|--|--|---|---|
| <div style="text-align: right;">8 4 2 9 9 7 9</div> <div style="text-align: center;"> <b>CERTIFICATE OF DEATH</b><br/>           REG. NO.         </div>  |  |  |  |   |   |  |  |   |   |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Luther A. Justice</b>   |  |  |  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>November 18, 1984</b>                                 |  | 2b. HOUR<br>M   |   |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>1 3 23</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>61</b> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                            |  |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1902 E. 31st. St.</b> |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1902 E. 31st. St. 21218</b>   |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Bowling Justice</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Cora Jones</b> |  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>246-12-9923</b>   |  | 17. INFORMANT ADDRESS<br><b>Evelyn Barbour 1934 E. 31st. St.</b>  |   |  |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>esophageal cancer</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.                   |  |  |  |   |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 months</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |   |   |  |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |  |  |   |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |  |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/10</b> , 19 <b>84</b> , to <b>11/18</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>11/14</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |  |  |   |   |
| 22b. SIGNATURE<br><b>Joseph E. Trojak</b> MD  |  |  |  |   |   | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>11/19/84</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Joseph E. Trojak MD</b>   |  |  |  |   |   | 22e. ADDRESS<br><b>Wyman Park Health System</b>  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11/21/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Forest VA</b>   |   | 23d. LOCATION CITY OR TOWN COUNTY<br><b>Owings Mills MD</b>                                  |  |   |   |
| 24. FUNERAL DIRECTOR NAME<br><b>Wm. C. March F/H 1101 E. North Ave.</b>   |  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 19 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Lelia Davidson-Randall</b>   |   |

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FOR  
1- STATE  
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 9 9 8 0  
REG. NO.

|  |         |  |  |   |  |   |  |  |  |                                |  |   |  |   |  |
|--|---------|--|--|---|--|---|--|--|--|--------------------------------|--|---|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)   |         | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE KNOWN OF DEATH ESTI-<br>MATED   |  | MONTH DAY YEAR                 |  | 2b. HOUR  |  |   |  |
| Donald   |         | Charles  |  | Kaiser  |  |   |  | <input checked="" type="checkbox"/> 11/17/84   |  |                                |  | M   |  |   |  |
| 3 SEX  | 4. RACE | 5 DATE OF BIRTH  |  | 6 AGE (IN YEARS<br>LAST BIRTHDAY)   |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.   |  | 7c. DATE<br>PRONOUNCED<br>DEAD |  | 7d. HOUR  |  |   |  |
| Male   | White   | 3 09 16  |  | 68 YRS.   |  | MONTHS DAYS   |  | HOURS MIN  |  | 11/17/84                       |  | 12:36<br>A M                                    |  |   |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |  |  |                                |  |   |  |   |  |
| Maryland   |         | U.S.A.   |  |   |  | Baltimore City,   |  |  |  |                                |  | MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY  |  |  |  |                                |  |   |  |   |  |
| Baltimore  |         | University Hospital Shock Trauma   |  | Water & Sewage Dept. Balto. Co.   |  |   |  |  |  |                                |  |   |  |   |  |
| 13a. STATE   |         | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS  |  |                                |  |   |  |   |  |
| Md.  |         | Baltimore  |  | Ellicott City   |  |   |  | 2403 Westchester Ave, Ellicott   |  |                                |  | 21043   |  |   |  |
| 14 FATHER'S NAME   |         | 15. MOTHER'S MAIDEN NAME   |  |   |  |   |  |  |  |                                |  |   |  |   |  |
| Charles  |         | Michael  |  | Kaiser  |  | Anna  |  | Katherine  |  | Grine                          |  | City  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |         | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS   |  |  |  |                                |  |   |  |   |  |
| No   |         | 215-24-7985  |  | Lawrence Kaiser   |  | 2407 Westchester Ave.   |  |  |  |                                |  | 21043   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:  |         |  |  |   |  |   |  |  |  |                                |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |   |  |
| 8147 IMMEDIATE CAUSE (a) Head Injuries   |         |  |  |   |  |   |  |  |  |                                |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |   |  |   |  |  |  |                                |  |   |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.  |         |  |  |   |  |   |  |  |  |                                |  |   |  |   |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |   |  |   |  |  |  |                                |  |   |  |   |  |
| (c)  |         |  |  |   |  |   |  |  |  |                                |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |         |  |  |   |  |   |  |  |  |                                |  |   |  |   |  |
| 19a. DATE OF OPERATION   |         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                |  |                                |  |   |  |   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |  |  | 21b. TIME OF INJURY<br>HOUR <del>XX</del> MONTH DAY YEAR<br>8:37 P.M. 11/8/ 19 84   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>subject pedestrian struck by auto |  |                                |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK   |         |  |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)<br>street  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>Westchester Ave, Balto. City, Md.                             |  |                                |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on<br>death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |         |  |  |   |  |   |  |  |  |                                |  |   |  |   |  |
| ACTUAL SIGNATURE <i>Margarita A. Korell</i> TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER   |         |  |  |   |  |   |  |  |  |                                |  | DATE SIGNED 11/17/84                            |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn St.   |         |  |  |   |  |   |  |  |  |                                |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |         |  |  | 23b. DATE   |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |                                |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE      |  |   |  |
| Burial   |         |  |  | 11/20/84  |  |   |  | Good Shepherd Cemetery   |  |                                |  | Ellicott City Md.                               |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br>Leroy M. & Russell C. Witzke Funeral Home   |         |  |  |   |  |   |  |  |  |                                |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 20 1984    |  | 25b. REGISTRAR'S SIGNATURE<br><i>Freda Davidson-Randall</i> |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR OUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



20% COTTON FIBRE

WATER-PROOF

BOND



Wm. & J. P. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called for an autopsy.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 4 2 9 9 8 1  
CERTIFICATE OF DEATH

|   |  |  |  |
|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>LILLIAN KANDEL  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>NOV. 1ST 1984  |  |
| 3. SEX<br>FEMALE  |  | 2b. HOUR<br>8:20A.M.   |  |
| 4. RACE<br>CAUCASIAN  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS.   |  |
| 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>AUG. 30 1906  |  | 8. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>DIST. OF COLUMBIA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>VERINAVE HEBREW GERIATRIC CENTER + HOSPITAL |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME   |  |
| 13a. STATE<br>MARYLAND  |  | 13b. COUNTY<br>BALTIMORE   |  |
| 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 13e. STREET ADDRESS / ZIP CODE<br>3318 E. CLARKS LANE 21211   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>SAMUEL LAVENSTEIN   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>BESSIE GANN   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>216-28-1519  |  |
| 17. INFORMANT<br>GERALD J. KANDEL   |  | 8405 TOPPING RD. 21208   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) GI BLEED<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) PROB. STRESS ULCER<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) CEREBROVASCULAR ACCIDENT           |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br>3/P CORONARY BY-PASS, 3/P MITRAL VALVE REPLACEMENT, 3/P TRACHEOSTOMY + GASTROSTOMY  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |
| 21c. HOW INJURY OCCURRED (Enter nature of injury in item 18, Part 1 or Part 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from 10/28/84 to 11/1/84, that (we) last saw the deceased alive on 11/1/84, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br>Esterlita O. Kw. my.  |  | 22c. DATE SIGNED<br>11/1/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ESTRELITA O. KW. my.   |  | 22e. ADDRESS<br>VERINAVE HEBREW GERIATRIC CENTER + HOSPITAL  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) BURIAL   |  | 23b. DATE<br>NOV. 2, 1984  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>CHIZUK AMUNO  |  | 23d. LOCATION<br>BALTIMORE MARYLAND  |  |
| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.<br>ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 7 1984  |  |
| 25b. REGISTRAR'S SIGNATURE<br>Lisa Davidson-Randall   |  |  |  |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |  |  |  |  |   |  | 8 4 2 9 9 8 2                                |
|--|--|--|--|--|--|--|--|---|--|--|
| 1- FOR STATE REGISTRAR   |  | HERMAN JOHN KANELEY  |  |  |  | CERTIFICATE OF DEATH   |  |   |  | REG. NO.                                     |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST  |  | MIDDLE   |  | LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR                                     |
| HERMAN   |  | J.   |  | KANELEY  |  |  |  | 11 14 84  |  | 7 50 A.M.                                    |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.                  |
| Male   |  | Cauc.  |  | 10/20/14   |  | 70 YRS.  |  |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |  |
| Virginia   |  | USA  |  |  |  | Balto. City MD.  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| Balto.   |  | Union Memorial Hospital  |  |  |  | Mailer   |  | News Amer.  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS   |  |  |
| Md.  |  | -  |  | Balto.   |  |  |  | 3204 Ramona Ave. 21213  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |   |  |  |
| John G. Kaneley  |  |  |  | Minnie Ash   |  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT  |  | ADDRESS  |  |   |  |  |
| No   |  | -  |  | 212-01-5963  |  | Dennis Kaneley, same address   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Cardiac Arrest   |  |  |  |  |  |  |  |   |  | Minutes                                      |
| DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction   |  |  |  |  |  |  |  |   |  | Minutes                                      |
| DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis  |  |  |  |  |  |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |  |  |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)   |  |  |  |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 83, to 19 84, that (I) (we) last saw the deceased alive on 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |   |  |  |
| 22b. SIGNATURE   |  |  |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS   |  | 11/14/84   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |   |  |  |
| Burial   |  | 11/17/84   |  | Parkwood   |  | Balto., Md.  |  |   |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |
| Schimunek Funeral Home, Inc. 3331 Brehms Lane, Balto., Md. 21213   |  |  |  |  |  | NOV 19 1984  |  | Julia Davidson-Randall  |  |  |

AT THE OFFICE OF THE  
SHERIFF OF THE COUNTY OF  
SANTA FE, NEW MEXICO

IN WITNESS WHEREOF, I have hereunto set my hand and the seal of said Office, this 1st day of May, 1903.

DECEASED  
100% COTTON



A. D. 1903

ATTEST:

30-11-1903

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 4 2 9 9 8 3  
CERTIFICATE OF DEATH

REG. NO.

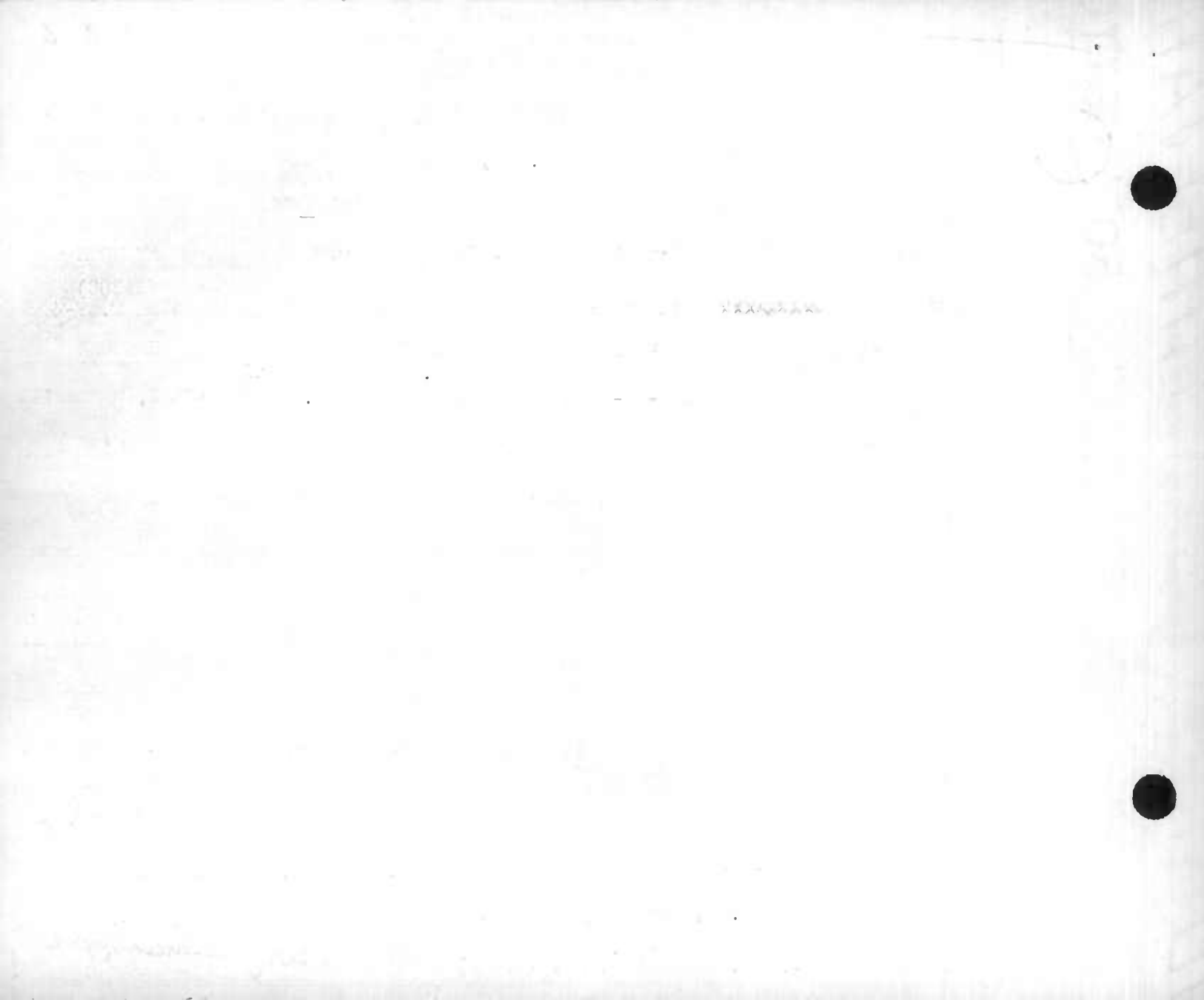
|   |  |  |  |   |                          |  |
|---|--|--|--|---|--------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MARSHA KAPLOW</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>NOVEMBER 27, 1984</b> |   | 2b. HOUR<br><b>11 AM</b> |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>SEPT. 27, 1902</b>  |                          | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>POLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                          | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY City MD.</b>   |
| 10. CITY OR TOWN OF DEATH<br><b>PIKESVILLE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>7211 BROOKCREST WAY APT. T-4</b> |  |   |                          | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>                                       |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |                          | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>SHEPPARD LEVITZ</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>HANNAH UNKNOWN</b>   |  |   |                          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>218-46-0818</b>   |  | 17. INFORMANT<br><b>DR. SHEPPARD KAPLOW</b>   |                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary occlusion</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerotic Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>15 years</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |  |   |                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hr</b>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 11c.   |  |  |  |   |                          |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                          | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |                          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>June 10</b> 19 <b>62</b> , to <b>Nov 27</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>November 27</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                            |  |  |  |   |                          |  |
| 22b. SIGNATURE<br><b>Leonard Wallenstein</b>  |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>11/27/84</b>   |                          | 22d. ADDRESS<br><b>711 W. 40th St. Balto., Md.</b>   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>NOV. 28, 1984</b>  |  | 23c. NAME OF CEMETERY OR CREMATOR<br><b>LUBAWITZ NUSACH ARI</b>   |                          | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ROSEDALE, BALTO., MD.</b>   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS.</b><br><b>6010 REISTERSTOWN RD. BALTIMORE, MD. (21215)</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 3 1984</b>  |                          |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 9 8 4  
REG. NO.

|   |  |   |  |   |
|---|--|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>REBECCA KATZ</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 25 84</b>  |  | 2b. HOUR<br><b>9:00 PM</b>  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>05 XX 1980</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>94</b> YRS.                                    |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>ROMANIA</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>   |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>YECTA BREITBART</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>LORA UNKNOWN</b>  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>217-48-5241</b>  |  | 17. INFORMANT<br><b>MR. ALBERT KATZ</b><br><b>6525 COPPERFIELD RD. BALTO., MD 21209</b>         |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) _____<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral Vascular Accident</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |   |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)  |  |   |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |   |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-24</b> , 19 <b>84</b> , to <b>11-25</b> , 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>11-25</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |
| 22b. SIGNATURE<br><b>John Southern</b>  |  | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11-25-84</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>John Southern</b>   |  | 22e. ADDRESS<br><b>Sinai Hospital</b>   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>NOV. 27, 1984</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>KOVNA</b>                                   |   |
| 23d. LOCATION<br><b>ROSEDALE BALTO. MD</b>  |  |   |  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b>   |  | 25. DATE REC'D BY REGISTRAR<br><b>DEC 3 1984</b>  |  |   |
| 6010 REISTERSTOWN RD. BALTO., MD 21215  |  |   |  |   |

1

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 9 8 5

REG. NO.

|  |  |  |   |   |   |
|--|--|--|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JONAS KAZLAUSKAS</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 21, 1984</b>                                 |   | 2b. HOUR<br><b>12:45</b> <sup>P</sup>   |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>02 08 16</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS<br>IF UNDER 1 YEAR: MONTHS DAYS<br>IF UNDER 24 HRS: HOURS MIN. |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>LITHUANIA</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>ACTOR</b>                |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>ACTING</b>  |
| 11. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br><b>MARYLAND BALTIMORE CATONSVILLE</b>   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOKAUBAS KAZLAUSKAS</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>VALARIE TUBINAS</b>                         |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>212-44-4004</b>   |   | 17. INFORMANT ADDRESS<br><b>GEDIMINAS KAZLAUSKAS 3502 GREENVALE RD. 21229</b>                                   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pseudomonas Sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Small Cell Cancer</b>  |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 min</b><br><b>3 days</b><br><b>6 weeks</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:a  |  |  |   |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>11/19</b> , 19 <b>84</b> , to <b>11/21</b> , 19 <b>84</b> , that (1) (we) lost<br>saw the deceased alive on <b>11/21</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (1) (we) (did) (did not) view the body after death. |  |  |   |   |   |
| 22b. SIGNATURE<br><b>Charles B. Treasure</b>   |  | DEGREE<br><b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>11/21/84</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Charles B. Treasure</b>  |  | 22e. ADDRESS<br><b>600 N. Wolfe Balto, MD 21205</b>  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>11-24-84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK</b>  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HUBBARD FUNERAL HOME, INC.</b>  |  | ADDRESS<br><b>4107 WILKENS AVE.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 23 1984</b>   |   |
|  |  |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Solia Davidson-Randall</b>   |   |

MEDICAL CERTIFICATION

BP.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the medical certificate be retained by the hospital or attending physician. This 24-hour certificate is not to be destroyed until 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the funeral director, it should be detached for use as the burial-transit permit. Then please send it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 is marked, a medical examiner must be notified.

01/02/19  
RECEIVED  
21/02/19

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CP

11 Feb 19

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 9 8 6

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |  |   |  |   |   |  |  |
|---|--|--|--|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><i>William T. Keene Sr.</i>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>Nov. 22, 1984</i>            |   |  | 2b. HOUR<br>M<br><i></i>  |   |  |  |
| 3. SEX<br><i>Male</i>   |  | 4. RACE<br><i>White</i>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>March 7, 1914</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><i>70</i>  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE<br>COUNTRY<br><i>Maryland</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                               |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>717 Patapsco Ave. Balto. Md. 21225</i> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Ret. Railroad</i>        |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><i>Maryland</i>   |  | 13b. COUNTY<br><i>-----</i>  |  | 13c. CITY OR TOWN<br><i>Baltimore</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br><i>717 E. Patapsco Ave. 21225<br/>1501 Jackson St. Balto. Md. 21230</i>                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Clarence M. Keene</i>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Nora ----- Unknown</i>  |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>   |  | 16b. SOCIAL SECURITY NO.<br><i>705-14-1386</i>   |  | 17. INFORMANT ADDRESS<br><i>Mr. George L. Keene, Sr. Same as above</i>  |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>SEVERE DEHYDRATION SEC. TO CA. STOMACH</i><br>DUE TO, OR AS A CONSEQUENCE OF <i>W/ GEN. METASTASIS</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <i>ASCUD - CHF - AT. FIBRILLATION</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>DIABETES MELLITUS TYPE II</i> |  |  |  |   |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i></i>  |  |  |  |   |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><i>"PT. DIED IN THE HOUSE"</i> |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1/84</i> , 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <i>11/20/84</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |   |  |  |
| 22b. SIGNATURE<br><i>R.N. PATALINGHUS MD</i>  |  |  |  |   | DEGREE<br><i></i>  |   | 22c. DATE SIGNED  |  |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |   | 22e. ADDRESS<br><i>403 E PATAPSCO AVE BALTO MD</i>   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>   |  |  | 23b. DATE<br><i>Nov. 26, 1984</i>                                      |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Glen Haven Mem. Park</i>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY<br><i>Glen Burnie, A.A. Co. Maryland</i> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>McCutty Funeral Home, 130 E. Fort Ave. Balto. Md.</i>  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><i>NOV 27 1984</i>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>W. J. [Signature]</i>                        |  |  |

MEDICAL CERTIFICATION

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with Form 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |   |   | REG. NO. 84 29987                            |   |  |  |  |                       |  |
|---|--|--|--|--|--|---|--|---|---|--|---|--|--|--|-----------------------|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  | 1. DECEASED NAME (TYPE OR PRINT) <u>William R. KELLY</u> |   |  |   |   |  |   | 2a. DATE OF DEATH MONTH <u>11</u> DAY <u>17</u> YEAR <u>84</u> |  |  | 2b. HOUR <u>10 PM</u> |  |
| 3. SEX <u>Male</u>  |  | 4. RACE <u>Black</u>   |  | 5. DATE OF BIRTH MONTH <u>9</u> DAY <u>02</u> YEAR <u>82</u>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <u>82</u> YRS                                     |  |   | IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u> |  | IF UNDER 24 HRS. HOURS <u></u> MIN. <u></u> |  |  |  |                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>   |  | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Balto. City</u> MD.                       |  |   |   |  |   |  |  |  |                       |  |
| 10. CITY OR TOWN OF DEATH <u>Balto.</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>DEATON HOSPITAL Medical Center</u> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  |   | 12b. KIND OF BUSINESS OR INDUSTRY           |  |   |  |  |  |                       |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |   |   |  |   |  |  |  |                       |  |
| 13a. STATE <u>Md.</u>   |  | 13c. CITY OR TOWN <u>Balto.</u>  |  | 13e. STREET ADDRESS / ZIP CODE <u>4049 Brummel Rd. 21211</u>   |  |   |  |   |   |  |   |  |  |  |                       |  |
| 14. FATHER'S NAME FIRST <u>Joshua</u> MIDDLE <u></u> LAST <u>Kelly</u>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST <u>Margaret</u> MIDDLE <u></u> LAST <u>Johnson</u>  |  |   |  |   |   |  |   |  |  |  |                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>   |  | 16b. SOCIAL SECURITY NO. <u>212-18-3602</u>  |  | 17. INFORMANT ADDRESS <u>Lela B. Smith 4049 Brummel Rd. 21122</u>  |  |   |  |   |   |  |   |  |  |  |                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lung Cancer</u>  |  |  |  |  |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |   |  |  |  |                       |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u></u>  |  |  |  |  |  |   |  |   |   |  |   |  |  |  |                       |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u></u>   |  |  |  |  |  |   |  |   |   |  |   |  |  |  |                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>  |  |  |  |  |  |   |  |   |   |  |   |  |  |  |                       |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |   |  |  |  |                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |   |   |  |   |  |  |  |                       |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |   |  |   |  |  |  |                       |  |
| 22a. I certify that (I) (his hospital) attended the deceased from <u>10-25-84</u> , 19 <u>84</u> , to <u>11-17</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>11-17</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |   |   |  |   |  |  |  |                       |  |
| 22b. SIGNATURE <u>Lalah Newbrough MD</u>  |  |  |  | DEGREE   |  |   |  | 22c. DATE SIGNED <u>11-18-84</u>  |   |  |   |  |  |  |                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Lalah Newbrough</u>  |  |  |  | 22e. ADDRESS <u>301 Marydell Rd, Balto 21229</u>   |  |   |  |   |   |  |   |  |  |  |                       |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>   |  | 23b. DATE <u>11-24-84</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Church Cem.</u>  |  |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Anne Arudel Co.</u>  |   |  |   |  |  |  |                       |  |
| 24. FUNERAL DIRECTOR NAME <u>Wm. C. March F/H 1101 E. North Ave.</u> ADDRESS  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <u>NOV 20 1984</u>   |  | 25b. REGISTRAR'S SIGNATURE <u>Lela Davidson-Rendell</u>                           |  |   |   |  |   |  |  |  |                       |  |





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified of this.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |   |   |   | 84 29988   |  |
|---|---|---|---|--|--|
| 1. FOR STATE REGISTRAR  |   |   |   | REG. NO.   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>REBECCA M. KERN</b>   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11 19 84</b>                             |  | 2b. HOUR<br><b>6:35 PM</b>   |
| 3. SEX<br><b>FEMALE</b>   | 4. RACE<br><b>CAUCASIAN</b>   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>7 10 07</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.                              | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>W. Virginia</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.              |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Montebello Center</b> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Seamstress</b>   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE COUNTY<br><b>Florida Palm Beach</b>   |   |   | 13b. CITY OR TOWN<br><b>Lakeworth</b>   | 13c. STREET ADDRESS<br><b>3125 Alice Dr. 33461</b>                             |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>William Whetsel</b>   |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Birdie Snelson</b>             |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>236-03-1689</b>   |   | 17. INFORMANT (Sister) ADDRESS<br><b>2600 Southern Ave Balto., Md. 21214</b>   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PROBABLE MYOCARDIAL INFARCTION</b>  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>IMMEDIATE</b>   |
| DUE TO, OR AS A CONSEQUENCE OF (b)  |   |   |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |   |   |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |   |   |   |  |  |
| 22b. SIGNATURE DEGREE<br><b>John C. Lett Her Jr M.D.</b>  |   |   |   | 22c. DATE SIGNED<br><b>11/19/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOHN C. LETT HER JR M.D.</b>  |   |   |   | 22e. ADDRESS   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>11/24/84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>I O O F Cem.</b>                      |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Elkins Randolph W. Va.</b>  |   | 24. FUNERAL DIRECTOR NAME<br><b>E. Barnes Fleming Funeral Service Benson, Md.</b>   |   |  |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 21 1984</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 97-35-300.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 84 29989   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Freida Kershman   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>11 19 84  |  | 2b. HOUR<br>10:40AM  |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>12 5 04  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br>79   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>RUSSIA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore City   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Pleasant Manor Nursing Center |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>HOME  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.   |  |   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Baltimore   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Harry (HERSCHEL) Hahn  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Rachel (ZEIRA) Steinfeld  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO   |  |   |  | 16b. SOCIAL SECURITY NO.<br>213-74-2925   |  | 16c. PREDECESSANT ADDRESS<br>Pleasant Manor Nursing Center<br>- 4615 Park Hgts. Ave.                                       |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>metastatic cancer of liver</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____   |  |   |  | 18b. ADDRESS<br>LEE HAHN 27 N. COLLINGTON AVE.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>30 days   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/19</u> , 19 <u>84</u> , to <u>11/19</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>11/19</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Jaime Punzalan  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br>11/20/84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JAIME PUNZALAN   |  |   |  | 22e. ADDRESS<br>5214 Harford rd. Balto. md. 21214   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>11/20/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>TZEMECH SEDEK CEM.  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>BALTIMORE, MD.  |  |
| 24. FUNERAL DIRECTOR NAME<br>SOL LEVINSON & BROS. ADDRESS<br>6010 REISTERSTOWN RD. BALTO., MD. (21215)  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 28 1984  |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson   |  |

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NOTION 2000

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**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

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FOR  
 1- STATE  
 REGISTRAR

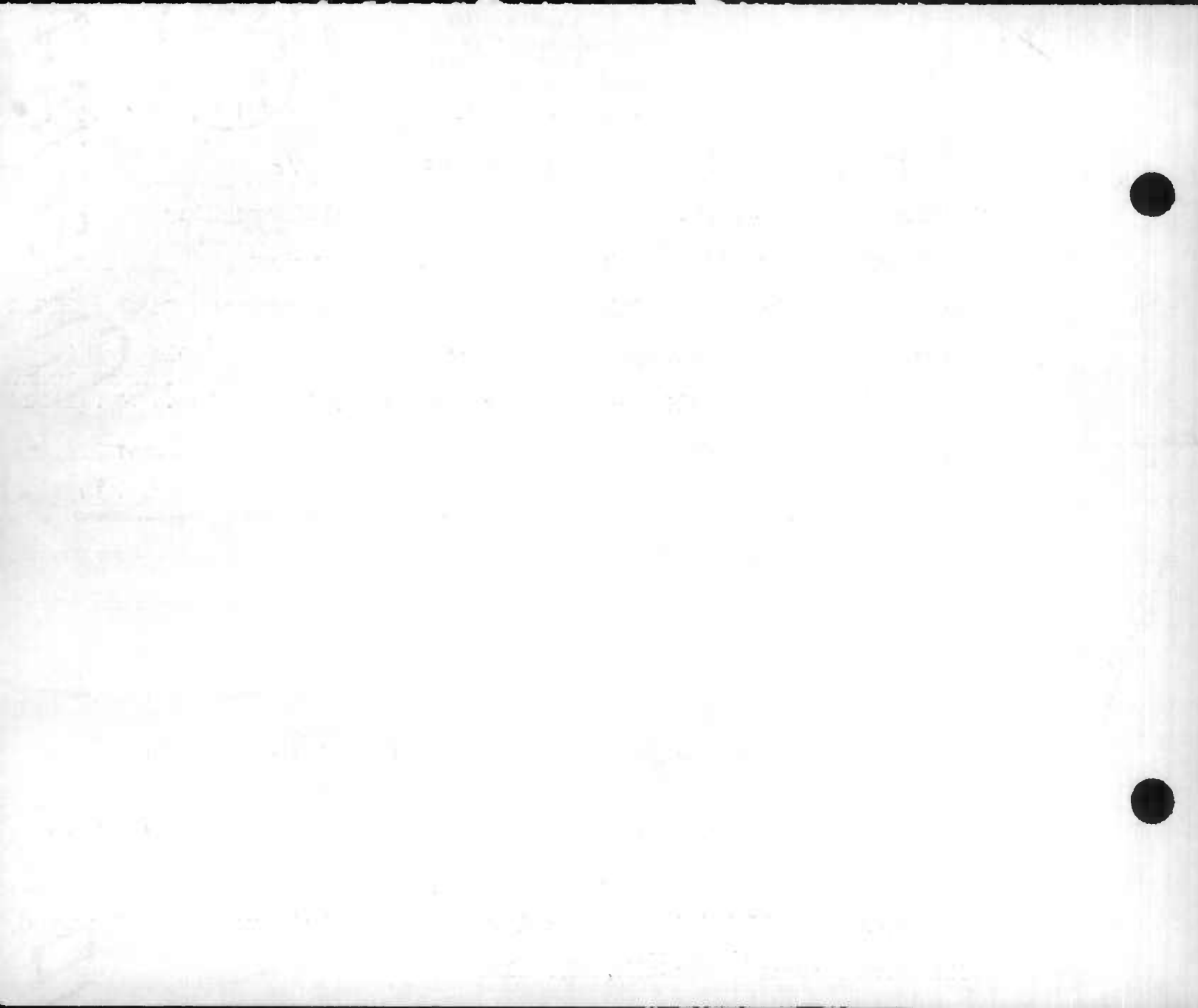
REG. NO.

|  |   |   |  |  |   |
|--|---|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Helen Lillian Kettenring</b>   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11 1 84</b>   |  | 2b. HOUR<br><b>2:14 A.M.</b>  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>4 3 38</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>46</b> YRS.                              | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.              |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Francis Scott Key Med.Center</b> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br><b>Maryland</b>  | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Dundalk</b>   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>7852 Kavanagh Road 21222</b>              |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Peter A. Mrowczynski</b>   |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Mary Olszewski</b>                          |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>219-26-2338</b>  | 17. INFORMANT ADDRESS<br><b>Mary Mrowczynski Balto., MD. 21224</b>                           |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio pulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>metastatic breast Ca</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>1-84 (10 months)</b>  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1-84</b>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>acute urinary retention</b>   |   |   |  |  |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>         | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10-17</b> , 19 <b>84</b> , to <b>11-1</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |  |  |   |
| 22b. SIGNATURE<br><b>Charles Wendt MD</b>  |   | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>11-1-84</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Charles Wendt MD</b>   |   | 22e. ADDRESS<br><b>FSK MC</b>   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>  |   | 23b. DATE<br><b>11/2/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview</b>                          |   |
| 23d. LOCATION CITY OR TOWN<br><b>Baltimore</b>   |   | COUNTY<br><b>Maryland</b>   |  | STATE  |   |
| 24. FUNERAL DIRECTOR NAME<br><b>Duda-Ruck, Inc.</b>  |   | ADDRESS<br><b>7922 Wise Avenue Dundalk, MD. 21222</b>   |  | 25. DATE REC'D. BY REGISTRAR<br><b>NOV 5 1984</b>                              |   |
| 26. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |   | 27. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8429991

1- FOR  
STATE  
REGISTRAR

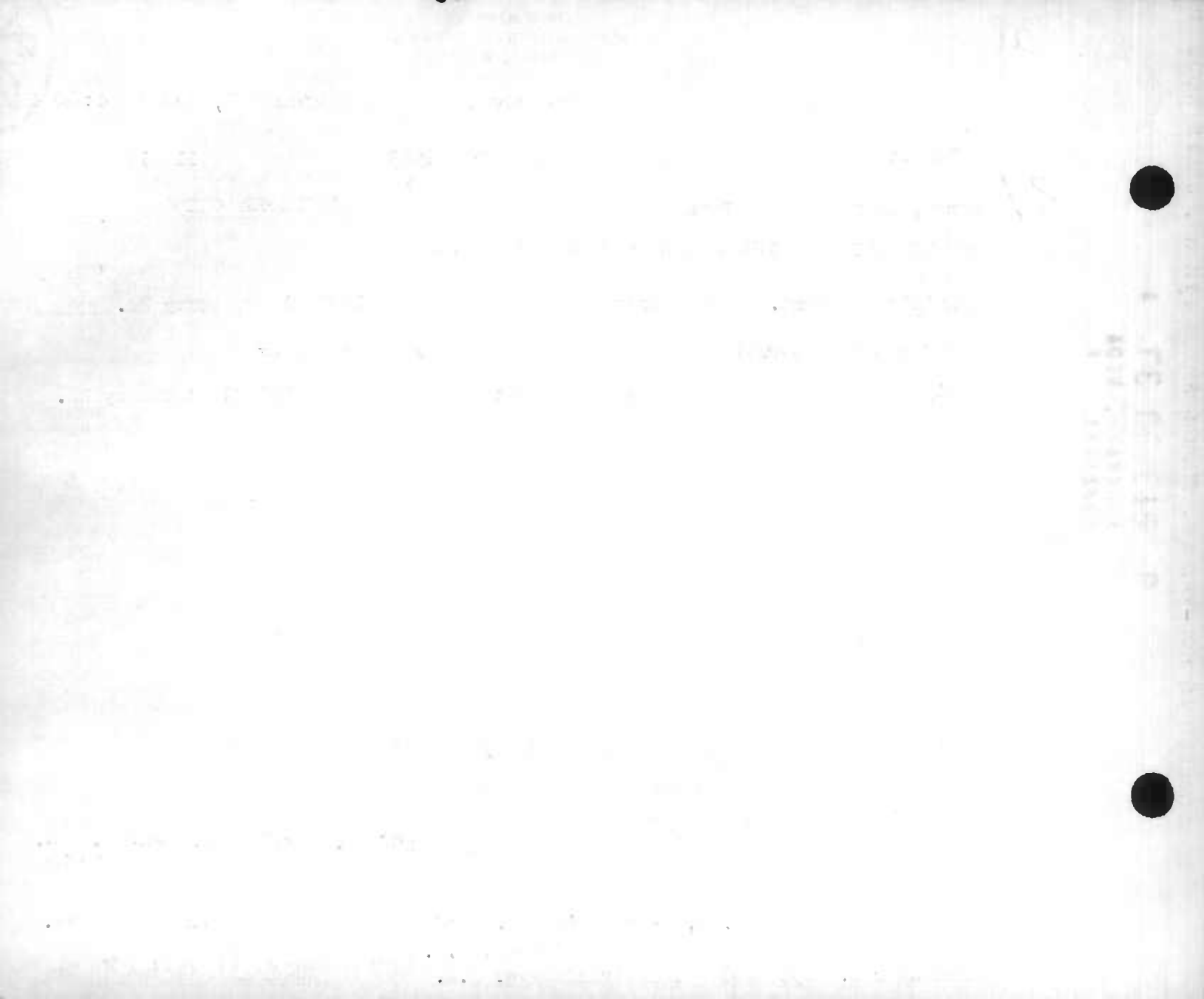
REG. NO.

|   |  |  |  |  |   |  |   |  |   |  |
|---|--|--|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Lillie - Keys  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 25 84                        |  |   | 2b. HOUR<br>305 AM   |   |  |   |  |
| 3. SEX<br>F   |  | 4. RACE<br>B   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>03 - 5 - 1884  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>100 YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |   |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD  |  | 9. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |   |  |   |  |
| 11. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Bon Secour Hospital |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>MD  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>4017 Liberty Hgts. Ave. 21207 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Noble Keys  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Louise Keys           |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  |  | 16b. SOCIAL SECURITY NO.<br>212-56-2944                                |  | 17. INFORMANT ADDRESS<br>Raymond Wade 2759 Raynor Ave.                        |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) ① Gastric Carcinoma<br>DUE TO, OR AS A CONSEQUENCE OF (b) ② Pseudomonas urinary tract infection<br>DUE TO, OR AS A CONSEQUENCE OF (c) ③ Pseudomonas colitis<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ④ Renal Insufficiency, CHF |  |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE                                    |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/15/84 to 11/25/84, that (I) (we) lost the deceased alive on 11/24/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br>MOSES GEBREMARIAH   |  |  | DEGREE<br>MD   |  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  | 22c. DATE SIGNED<br>11/25/84                                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MOSES GEBREMARIAH  |  |  | 22e. ADDRESS   |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |  | 23b. DATE<br>12/2/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Mem. Pk.                        |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co. MD                                  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H 1101 E. North Ave.   |  |  |  |  |   | 25. DATE REC'D. BY REGISTRAR<br>NOV 28 1984  |   |  |   |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 4 2 9 9 9 2  
REG. NO.

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1 - FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH MONTH DAY YEAR                                    |  | 2b. HOUR P M   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  |  | NOVEMBER 7, 1984  |  | 4:00 P M   |  |
| NEDA KHOSRAVI   |  |   |  |  |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  |
| Female  |  | Iranian   |  | Nov 22 1983  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.  |  |
| YRS 11  |  | 15  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| Tehran, Iran  |  | Iran  |  |  |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH  |  | 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   |  |
| BALTIMORE CITY MD.  |  | BALTIMORE   |  | THE JOHNS HOPKINS HOSPITAL   |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |
|   |  |   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13b. STATE  |  | 13c. CITY OR TOWN  |  |
| Rockville   |  | Mont.   |  | Iran   |  |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE                                      |  |  |  |
|   |  | 1737 Glastonberry Rd. 20834   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                          |  |  |  |
| Mansour Khosravi  |  | Fatemeh Moghaddam   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS  |  |
| No  |  | None  |  | Fatemeh Khosravi 1737 Glastonberry Rd.   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |  |  |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOW CARDIAC OUTPUT   |  | 7 hours   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) REPAIR OF TETRALOGY OF FALLOT  |  | 7 hrs 35 min  |  |  |  |
| (c) DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 11/7/84   |  | TETRALOGY OF FALLOT   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |
|   |  | P.M. 19   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION CITY OR TOWN COUNTY STATE  |  |
|   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/7/84 to 11/7/84, that (I) (we) last saw the deceased alive on 11/7/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE DEGREE   |  | 22c. DATE SIGNED   |  |
| George J. Papadopoulos Jr.  |  | M.D.  |  | 11/7/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |  | 22f. DATE RECD. BY REGISTRAR   |  |
| George J. Papadopoulos Jr.  |  | 800 N. WOLFE ST. BALTO. MD. THE JOHNS HOPKINS HOSPITAL 21205        |  | 22g. REGISTRAR'S SIGNATURE   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| Burial  |  | Nov. 9, 1984  |  | Nat'l Mem. Park  |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE   |  | 23e. DATE RECD. BY REGISTRAR  |  | 23f. REGISTRAR'S SIGNATURE   |  |
| Falls Church Va.  |  | NOV 8 1984  |  | John Davidson  |  |
| 24. FUNERAL DIRECTOR NAME   |  | 24b. ADDRESS  |  | 24c. DATE RECD. BY REGISTRAR   |  |
| Alexander S. Pope   |  | 2617 Pennsylvania Ave, S.E. Washington, D.C.                        |  | NOV 8 1984   |  |



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 9 9 3

REG. NO.

|  |   |   |   |  |   |
|--|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ALBERT S KIERSAKSKY</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 8 84</b>                               |  | 2b. HOUR<br><b>1:00<sup>PM</sup></b>  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>08 27 24</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>60</b> YRS.                                    |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. CITY</b> MD.                       |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO CITY</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Engineer</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br><b>MD</b>  |   |   | 13b. COUNTY<br><b>Howard</b>  | 13c. CITY OR TOWN<br><b>ELlicott CITY</b>  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>late John KIERSAKSKY</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>1ste IRENE WRLAKIS</b>          |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II 216-14-7351</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Mrs Claire KIERSAKSKY 2930 Eastway 21043</b>          |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>metastatic colon cancer</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |   |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |   |   |  |   |
| 19a. DATE OF OPERATION<br><b>NA</b>  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/4</b> , 19 <b>84</b> , to <b>11/8</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>11/4</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |   |  |   |
| 22b. SIGNATURE<br><b>David Schamp MD</b>   |   |   |   | 22c. DATE SIGNED<br><b>11/8/84</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DAVID SCHAMP MD</b>  |   |   |   | 22e. ADDRESS<br><b>22 S. Francis ST BALTO MD 21201</b>                               |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>Nov 12'84</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Crestlawn</b>                              |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Howard Maryland</b>  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Harry H Witzke 4112 Columbia Rd Ellicott City</b>   |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 9 1984</b>                                   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Lelia Davidson-Randall</b>  |   |   |   |  |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18, show only injury, or other traumatic event, if required; and examiner must be notified at once.

2004-2005

1952-1953

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND  |  |  |  |  |   |                                      |  |                                   |  |
|--|--|--|--|--|---|--------------------------------------|--|-----------------------------------|--|
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  |   |                                      |  |                                   |  |
| CERTIFICATE OF DEATH   |  |  |  |  |   |                                      |  |                                   |  |
| REG. NO. 8 4 2 9 9 9 4   |  |  |  |  |   |                                      |  |                                   |  |
| 1. FOR STATE REGISTRAR   |  |  |  |  | 2a. DATE OF DEATH   |                                      |  |                                   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR                                    |                                      |  |                                   |  |
| FIRST MIDDLE LAST  |  |  |  |  | 2b. HOUR  |                                      |  |                                   |  |
| Apple Pie Knight   |  |  |  |  | 10 24 84 5 20 PM  |                                      |  |                                   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |   | 6. AGE (IN YEARS LAST BIRTHDAY)      |  | 7. IF UNDER 1 YEAR                |  |
| FEMALE   |  | C White  |  | MONTH DAY YEAR   |   | MONTHS DAYS                          |  | HOURS MIN.                        |  |
| 10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| Maryland   |  | USA  |  |  |   | City                                 |  | MD.                               |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |   | 12b. KIND OF BUSINESS OR INDUSTRY    |  |                                   |  |
| Baltimore  |  | Sinai Hospital   |  |  |   |                                      |  |                                   |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13d. INSIDE CITY LIMITS?   |   | 13e. STREET ADDRESS / ZIP CODE       |  |                                   |  |
| Md.  |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 1419 Third Rd.                       |  | 21220                             |  |
| 14. FATHER'S NAME  |  |  |  |  | 15. MOTHER'S MAIDEN NAME  |                                      |  |                                   |  |
| FIRST MIDDLE LAST  |  |  |  |  | FIRST MIDDLE LAST   |                                      |  |                                   |  |
| William Knight   |  |  |  |  | Deborah S. Hammer   |                                      |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  |  | 16b. SOCIAL SECURITY NO.  |                                      | 17. INFORMANT  |                                   |  |
| NO   |  |  |  |  |   |                                      | Birth certif.  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |  |  |  |   |                                      |  |                                   |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |   |                                      |  |                                   |  |
| IMMEDIATE CAUSE (a) cessation of heart rate  |  |  |  |  |   |                                      |  |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |   |                                      |  |                                   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |  |  |  |  |   |                                      |  |                                   |  |
| (b) extreme immaturity   |  |  |  |  |   |                                      |  |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |   |                                      |  |                                   |  |
| (c)  |  |  |  |  |   |                                      |  |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:                   |  |  |  |  |   |                                      |  |                                   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?   |                                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                                   |  |
|  |  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                      | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |                                      |  |                                   |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |  |  |   |                                      |  |                                   |  |
|  |  | P.M. 19  |  |  |   |                                      |  |                                   |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION  |   |                                      |  |                                   |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | CITY OR TOWN COUNTY STATE  |   |                                      |  |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost                           |  |  |  |  |   |                                      |  |                                   |  |
| saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated            |  |  |  |  |   |                                      |  |                                   |  |
| 22b. SIGNATURE   |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |   | 22c. DATE SIGNED                     |  |                                   |  |
| Jonathan Surell  |  | MD   |  |  |   | 10/24/84                             |  |                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |   |                                      |  |                                   |  |
| JONATHAN SURELL  |  | Belvedere at Greenspring Balb. MD 21415  |  |  |   |                                      |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION                        |  |                                   |  |
| Cremation  |  | 10-29-84   |  | Sinai Hospital   |   | Baltimore MD. 21215                  |  |                                   |  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |   |                                      |  |                                   |  |
| Sinai Hospital   |  | 1 NOV 24 1984  |  | John S. S. S. S.   |   |                                      |  |                                   |  |

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BOND

CHIEF

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |                |                 |  |  |  |  |   |                |   |  |   |  |  |                            |  |  |  |  |
|--|--|----------------|-----------------|--|--|--|--|---|----------------|---|--|---|--|--|----------------------------|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |                | FIRST<br>HATTIE |  |  | MIDDLE<br>A.   |  |   | LAST<br>KILSON |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>11 19 1984 |  |  | 2b. HOUR<br>M<br>6:50<br>A |  |  |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Col |                 | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4-28-1900  |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>84 YRS.            |  | IF UNDER 1 YR.<br>MONTHS DAYS   |                | IF UNDER 24 HRS.<br>HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>11 19 1984  |  |  | 2d. HOUR<br>M<br>6:50<br>A |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Towson, Md.   |  |                |                 | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD   |  |  |                            |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |                |                 | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Provident Hospital |  |  |  |   |                | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)<br>Homemaker |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY            |                            |  |  |  |  |
| 13a. STATE<br>Maryland   |  |                |                 | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Balto.                                |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                | 13e. STREET ADDRESS<br>2403 St Stephens Ct                                |  |   |  |  |                            |  |  |  |  |
| 14. FATHER'S NAME<br>Edward  |  |                |                 | MIDDLE<br>Augustus   |  | LAST<br>Lucas  |  | 15. MOTHER'S MAIDEN NAME<br>Emma  |                |   |  | MIDDLE<br>Lucas   |  | LAST<br>Lucas                                |                            |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>NO  |  |                |                 | 16b. SOCIAL SECURITY NO.<br>212-265609   |  | 17. INFORMANT<br>Mrs. Phoebe Senior                        |  |   |                | ADDRESS<br>2910 Elgin Ave.  |  |   |  |  |                            |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cranio-cerebral trauma</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |                |                 |  |  |  |  |   |                |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                            |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |                |                 |  |  |  |  |   |                |   |  |   |  |  |                            |  |  |  |  |
| 19a. DATE OF OPERATION   |  |                |                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |   |                |   |  |   |  |  |                            |  |  | 20. AUTOPSY?<br>HEAD ONLY<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                |                 | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>6:15 PM 11-19-1984  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Pedestrian struck by auto.   |                |   |  |   |  |  |                            |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |                |                 | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>road  |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>2400 blk. W. North Ave., Balto. City Md  |                |   |  | Head only at Moreland   |  |  |                            |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                |                 |  |  |  |  |   |                |   |  |   |  |  |                            |  |  |  |  |
| ACTUAL SIGNATURE<br>Ann M. Dixon   |  |                |                 | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER   |  |  |  |   |                |   |  |   |  | DATE SIGNED 11-19-84                         |                            |  |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Ann M. Dixon, M.D.   |  |                |                 | ADDRESS 111 Penn St., Balto., Md. 21201  |  |  |  |   |                |   |  |   |  |  |                            |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |                |                 | 23b. DATE<br>11-24-84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arlingwood Mem. Park |  |   |                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Co. Md               |  |   |  |  |                            |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Joseph L. Russ   |  |                |                 | ADDRESS<br>2222 W. North Ave.  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 21 1984  |                |   |  | 25b. REGISTRAR'S SIGNATURE<br>John Davidson   |  |  |                            |  |  |  |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 8 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 13c per phone 12/4/84 dad

STATE OF MARYLAND

1. FOR Item 8 G633 11-4-87  
STATE REGISTRAR per marr. cert

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 9 9 6

REG. NO.

|  |  |  |  |  |   |  |   |  |  |  |
|--|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Howard E Kilson Sr.</b>   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11/27/84</b>                    |  |   | 2b. HOUR<br><b>830 A</b>   |   |  |  |  |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>B</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>9 1 18</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS                               |   | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>Trop. M.D.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b> MD.                   |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University md Hospital</b> |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. STATE<br><b>MD</b>  |  |  |  |  | 13b. COUNTY<br><b>Baltimore</b>                                       |  | 13c. CITY OR TOWN<br><b>BALTO.</b>                                |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Kilson</b>  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary E. Young</b> |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>218040292</b>                           |  | 17. INFORMANT ADDRESS<br><b>Howard Kilson Jr 5335 Nelson Ave</b>      |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulm Collapse</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Widespread Metastatic Adenocarcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:   |  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/26</b> , 19 <b>84</b> , to <b>11/27</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>11/26</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                |  |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>S Papush</b>  |  |  | DEGREE   |  |   | 22c. DATE SIGNED<br><b>11/27/84</b>  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>P APUCATS</b>  |  |  | 22e. ADDRESS<br><b>11652 S Laurel Dr Laurel MD</b>                     |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>12-4-84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Shelock Vet. Cem.</b>        |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Easton, Ind.</b> |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leroy C. Sytt</b>   |  |  | ADDRESS<br><b>4600 Liberty Sgt Ave</b>                                 |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 30 1984</b>                            |   |  |  |  |

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Howard E. Kilson

18

William Kilson Mary E. Young

Howard E. Kilson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 84 29997  |  |   |  |   |  |
|---|--|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR 11-27-84  |  |   |  | 2b. HOUR 4:20 AM  |  |
| 1. DECEASED NAME (TYPE OR PRINT) Gladys M. Kincee   |  | 3. SEX Female   |  | 4. RACE White  |  | 5. DATE OF BIRTH MONTH DAY YEAR 5-10-01   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA  |  | 7b. CITIZEN OF WHAT COUNTRY? USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.                                |  |   |  |
| 10. CITY OR TOWN OF DEATH Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE, GIVE STREET ADDRESS) South Baltimore General Hospital |  |  |  | 12a. USUAL OCCUPATION (TYPE OF "LIVING LIFE") Housewife                           |  | 12b. KIND OF BUSINESS OR INDUSTRY Home Maker  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD  |  |   |  | 13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13c. STREET ADDRESS / ZIP CODE 935 Mayadon Ct 21225                               |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Daniel Monahan  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gladys Unknown   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) No  |  | 16b. SOCIAL SECURITY NO. 233-18-5550  |  | 17. INFORMANT ADDRESS Ruby White 917 Pontiac Avenue Balto Md 21225  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), (c), (d), (e), (f), (g), (h), (i), (j), (k), (l), (m), (n), (o), (p), (q), (r), (s), (t), (u), (v), (w), (x), (y), (z), (aa), (ab), (ac), (ad), (ae), (af), (ag), (ah), (ai), (aj), (ak), (al), (am), (an), (ao), (ap), (aq), (ar), (as), (at), (au), (av), (aw), (ax), (ay), (az), (ba), (bb), (bc), (bd), (be), (bf), (bg), (bh), (bi), (bj), (bk), (bl), (bm), (bn), (bo), (bp), (bq), (br), (bs), (bt), (bu), (bv), (bw), (bx), (by), (bz), (ca), (cb), (cc), (cd), (ce), (cf), (cg), (ch), (ci), (cj), (ck), (cl), (cm), (cn), (co), (cp), (cq), (cr), (cs), (ct), (cu), (cv), (cw), (cx), (cy), (cz), (da), (db), (dc), (dd), (de), (df), (dg), (dh), (di), (dj), (dk), (dl), (dm), (dn), (do), (dp), (dq), (dr), (ds), (dt), (du), (dv), (dw), (dx), (dy), (dz), (ea), (eb), (ec), (ed), (ee), (ef), (eg), (eh), (ei), (ej), (ek), (el), (em), (en), (eo), (ep), (eq), (er), (es), (et), (eu), (ev), (ew), (ex), (ey), (ez), (fa), (fb), (fc), (fd), (fe), (ff), (fg), (fh), (fi), (fj), (fk), (fl), (fm), (fn), (fo), (fp), (fq), (fr), (fs), (ft), (fu), (fv), (fw), (fx), (fy), (fz), (ga), (gb), (gc), (gd), (ge), (gf), (gg), (gh), (gi), (gj), (gk), (gl), (gm), (gn), (go), (gp), (gq), (gr), (gs), (gt), (gu), (gv), (gw), (gx), (gy), (gz), (ha), (hb), (hc), (hd), (he), (hf), (hg), (hh), (hi), (hj), (hk), (hl), (hm), (hn), (ho), (hp), (hq), (hr), (hs), (ht), (hu), (hv), (hw), (hx), (hy), (hz), (ia), (ib), (ic), (id), (ie), (if), (ig), (ih), (ii), (ij), (ik), (il), (im), (in), (io), (ip), (iq), (ir), (is), (it), (iu), (iv), (iw), (ix), (iy), (iz), (ja), (jb), (jc), (jd), (je), (jf), (jg), (jh), (ji), (jj), (jk), (jl), (jm), (jn), (jo), (jp), (jq), (jr), (js), (jt), (ju), (jv), (jw), (jx), (jy), (jz), (ka), (kb), (kc), (kd), (ke), (kf), (kg), (kh), (ki), (kj), (kk), (kl), (km), (kn), (ko), (kp), (kq), (kr), (ks), (kt), (ku), (kv), (kw), (kx), (ky), (kz), (la), (lb), (lc), (ld), (le), (lf), (lg), (lh), (li), (lj), (lk), (ll), (lm), (ln), (lo), (lp), (lq), (lr), (ls), (lt), (lu), (lv), (lw), (lx), (ly), (lz), (ma), (mb), (mc), (md), (me), (mf), (mg), (mh), (mi), (mj), (mk), (ml), (mm), (mn), (mo), (mp), (mq), (mr), (ms), (mt), (mu), (mv), (mw), (mx), (my), (mz), (na), (nb), (nc), (nd), (ne), (nf), (ng), (nh), (ni), (nj), (nk), (nl), (nm), (nn), (no), (np), (nq), (nr), (ns), (nt), (nu), (nv), (nw), (nx), (ny), (nz), (oa), (ob), (oc), (od), (oe), (of), (og), (oh), (oi), (oj), (ok), (ol), (om), (on), (oo), (op), (oq), (or), (os), (ot), (ou), (ov), (ow), (ox), (oy), (oz), (pa), (pb), (pc), (pd), (pe), (pf), (pg), (ph), (pi), (pj), (pk), (pl), (pm), (pn), (po), (pp), (pq), (pr), (ps), (pt), (pu), (pv), (pw), (px), (py), (pz), (qa), (qb), (qc), (qd), (qe), (qf), (qg), (qh), (qi), (qj), (qk), (ql), (qm), (qn), (qo), (qp), (qq), (qr), (qs), (qt), (qu), (qv), (qw), (qx), (qy), (qz), (ra), (rb), (rc), (rd), (re), (rf), (rg), (rh), (ri), (rj), (rk), (rl), (rm), (rn), (ro), (rp), (rq), (rr), (rs), (rt), (ru), (rv), (rw), (rx), (ry), (rz), (sa), (sb), (sc), (sd), (se), (sf), (sg), (sh), (si), (sj), (sk), (sl), (sm), (sn), (so), (sp), (sq), (sr), (ss), (st), (su), (sv), (sw), (sx), (sy), (sz), (ta), (tb), (tc), (td), (te), (tf), (tg), (th), (ti), (tj), (tk), (tl), (tm), (tn), (to), (tp), (tq), (tr), (ts), (tt), (tu), (tv), (tw), (tx), (ty), (tz), (ua), (ub), (uc), (ud), (ue), (uf), (ug), (uh), (ui), (uj), (uk), (ul), (um), (un), (uo), (up), (uq), (ur), (us), (ut), (uu), (uv), (uw), (ux), (uy), (uz), (va), (vb), (vc), (vd), (ve), (vf), (vg), (vh), (vi), (vj), (vk), (vl), (vm), (vn), (vo), (vp), (vq), (vr), (vs), (vt), (vu), (vv), (vw), (vx), (vy), (vz), (wa), (wb), (wc), (wd), (we), (wf), (wg), (wh), (wi), (wj), (wk), (wl), (wm), (wn), (wo), (wp), (wq), (wr), (ws), (wt), (wu), (wv), (ww), (wx), (wy), (wz), (xa), (xb), (xc), (xd), (xe), (xf), (xg), (xh), (xi), (xj), (xk), (xl), (xm), (xn), (xo), (xp), (xq), (xr), (xs), (xt), (xu), (xv), (xw), (xx), (xy), (xz), (ya), (yb), (yc), (yd), (ye), (yf), (yg), (yh), (yi), (yj), (yk), (yl), (ym), (yn), (yo), (yp), (yq), (yr), (ys), (yt), (yu), (yv), (yw), (yx), (yy), (yz), (za), (zb), (zc), (zd), (ze), (zf), (zg), (zh), (zi), (zj), (zk), (zl), (zm), (zn), (zo), (zp), (zq), (zr), (zs), (zt), (zu), (zv), (zw), (zx), (zy), (zz)) |  |   |  | PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-pulmonary Arrest   |  | DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction                          |  | DUE TO, OR AS A CONSEQUENCE OF (c)  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (i)  |  |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 84 11-27 19 84 to 11-27 19 84, that (I) (we) last saw the deceased alive on 11-27 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |   |  |   |  |
| 22b. SIGNATURE Dr. Buck, MD   |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | 22c. DATE SIGNED 11-27-84   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Buck, M.D.  |  | 22e. ADDRESS South Baltimore General Hospital   |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |  | 23b. DATE 11/30/84  |  | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto A.A. Md                             |  |   |  |
| 24. FUNERAL DIRECTOR George J. Gonce 4001 Ritchie Hgwy Balto Md   |  |   |  | 25. DATE REC'D. BY REGISTRAR DEC 3 1984  |  | 26. REGISTRAR'S SIGNATURE Julia Davidson-Randall                                  |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 9 9 8

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Elizabeth P. King</i>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>11-27-84</i>  |  | 2b. HOUR<br><i>3:20P</i> M   |
| 3. SEX<br><i>Female</i>  | 4. RACE<br><i>White</i>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>Aug. 19, 1888</i>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>96</i> YRS.                                | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>   | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Bon Secours Hospital</i> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK, FOR MOS, OF WORKING LIFE)<br><i>Retired Housewife</i> | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>N/A</i>                                  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>Maryland</i>  |  |   | 13b. COUNTY<br><i>Montgomery</i>  | 13c. CITY OR TOWN<br><i>Clarksburg</i>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Charles Penner</i>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Anne unknown</i>                          |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>No</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>212-88-1570</i>  |   | 17. INFORMANT<br><i>Charles N. King</i>  |  |
|  |  |   |   | ADDRESS<br><i>4829 Bushey Rd.<br/>Sykesville, Md. 21784</i>                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Pneumonia with Sepsis</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.      |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><i>Congestive Heart Failure</i>  |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>        | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>10/7</i> 19 <i>84</i> to <i>11/27</i> 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>11/27</i> 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |   |  |  |
| 22b. SIGNATURE<br><i>M. Reiman</i>   |  | DEGREE<br><i>M.D.</i>   |   | 22c. DATE SIGNED<br><i>11/28/84</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>M. Reiman</i>  |  | 22e. ADDRESS<br><i>Bon Secours Hosp.</i>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>  | 23b. DATE<br><i>Nov. 30, 1984</i>  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Clarksburg Meth.</i>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Clarksburg, Montgomery, Md.</i> |  |
| 24. FUNERAL DIRECTOR<br><i>Oliver L. Molesworth, P.A., Damascus, Md.</i>   |  |   | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><i>DEC 03 1984 John T. Davis</i>  |  |  |

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U.S. : Holmworth, E.L., Danvers, N.H.  
Mar. 30, 1984 Orlinburg, Tenn.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 9 9 9 9

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |  |   |   |  |  |  |   |   |   |   |  |
|---|--|---|---|--|--|--|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>James King Sr.</i>   |  |   | 2a. DATE OF DEATH<br>MONTH <i>11</i> DAY <i>28</i> YEAR <i>84</i> |  |  | 2b. HOUR<br><i>1:15</i> PM   |   |   |   |   |  |
| 3. SEX<br><i>Male</i>   |  | 4. RACE<br><i>Black</i>   |   | 5. DATE OF BIRTH<br>MONTH <i>8</i> DAY <i>17</i> YEAR <i>17</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>67</i>                                       |   | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>MD</i>                 |   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>MD</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A</i>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>     |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City MD.</i>                  |   |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Shari Hosp.</i> |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>retired</i> |   | 12b. KIND OF BUSINESS OR INDUSTRY                                     |   |   |  |
| 13a. STATE<br><i>MD.</i>  |  |   | 13b. COUNTY<br><i>Balt</i>  |  | 13c. CITY OR TOWN<br><i>Balt.</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br><i>1623 Rutland Ave. 21213</i>  |   |  |
| 14. FATHER'S NAME<br>FIRST <i>Thomas</i> MIDDLE LAST <i>King</i>  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <i>Ellen</i> MIDDLE LAST <i>Barefield</i>  |  |  |   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>NO</i>   |  |   | 16b. SOCIAL SECURITY NO.<br><i>217-09-2998</i>                    |  |  | 17. INFORMANT<br>ADDRESS<br><i>Doretha King 1623 Rutland Ave.</i>                  |   |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <i>Respiratory Arrest</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Widely Metastatic Colon Cancer</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |  |   |   |  |  |  |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11/23</i> 19 <i>84</i> to <i>11/28</i> 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>11/28</i> 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |  |  |  |   |   |   |   |  |
| 22b. SIGNATURE<br><i>Shari Sopher MD</i>  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  |   | 22c. DATE SIGNED<br><i>11/28/84</i>                                   |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>SHARI SOPHER</i>  |  |   |   | 22e. ADDRESS<br><i>Shari Hosp</i>  |  |  |   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>   |  |   | 23b. DATE<br><i>12/3/84</i>                                       |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Mt. Calvary Cem.</i>                  |  |   | 23d. LOCATION<br>CITY OR TOWN <i>Baltimore</i> COUNTY STATE <i>MD</i> |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Wm. C. March F/H 1101 E. North Ave.</i>  |  |   |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>NOV 29 1984</i>                                |   | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>           |   |   |  |

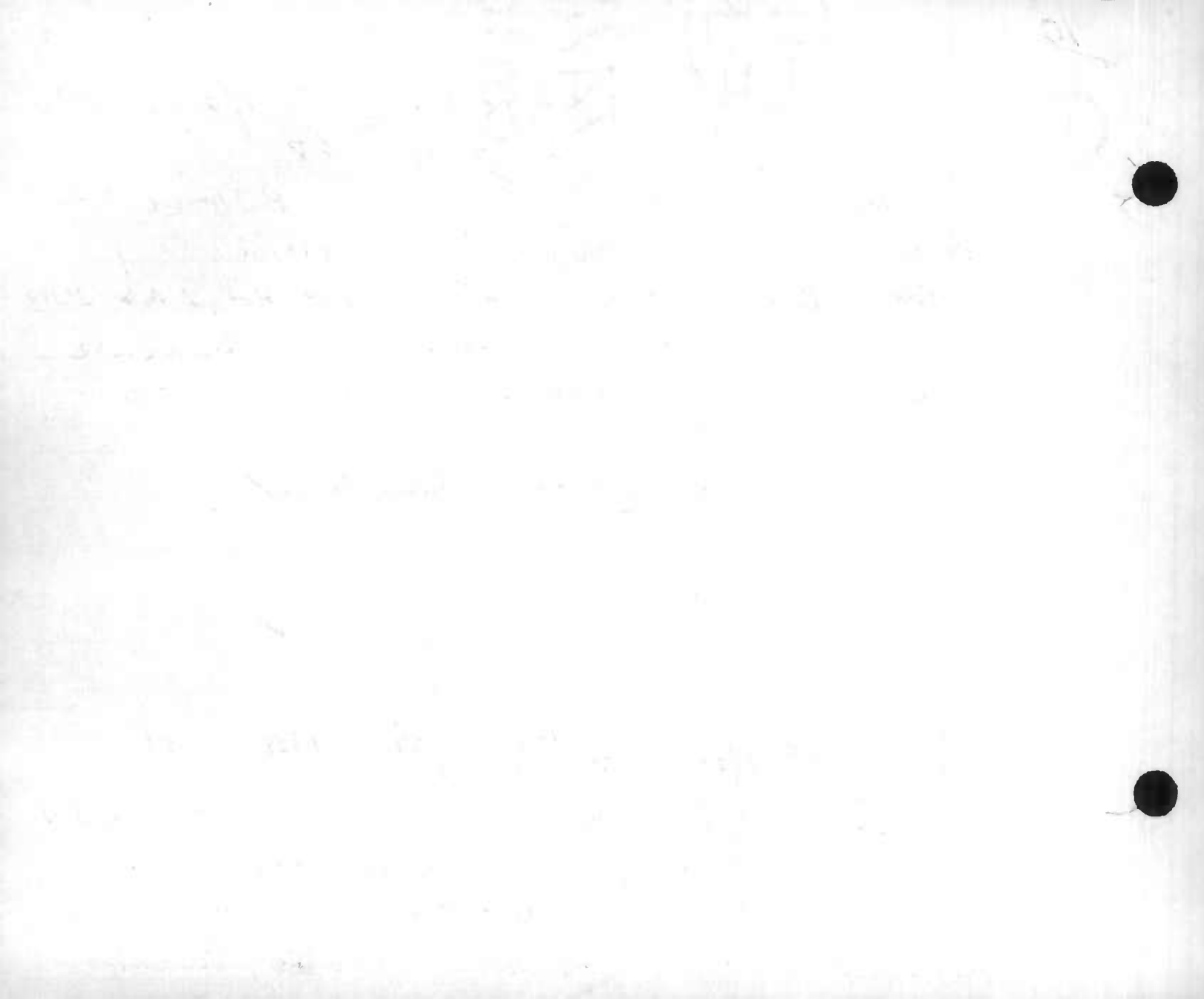
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |   |  |                           |  |   |  |
|--|--|---|--|---|---|--|---------------------------|--|---|--|
| 1- FOR STATE REGISTRAR   |  | JULIA M. KING   |  |   |   | REG. NO. 8430000   |                           |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Julia M. King   |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>11/13/84                      |  |                           | 2b. HOUR<br>10:00 PM   |   |  |
| 3 SEX<br>Female  |  | 4 RACE<br>Cauc.   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>8 14 134   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS.  |                           | 7. UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>US  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balt. CITY MD.                               |                           |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Balt.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SINAI |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker           |                           | 12b. KIND OF BUSINESS OR INDUSTRY<br>-   |   |  |
| 13a. STATE<br>Md   |  |   |  |   | 13b. COUNTY<br>Balt   |  | 13c. CITY OR TOWN<br>Balt |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Orlando D'Alessandro  |  |   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Josephine (Unknown) |  |                           |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>215-07-1664   |  | 17. INFORMANT ADDRESS<br>Frank J. King, III, same address   |   |  |                           |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) Respiratory Arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Brain damage; Sepsis<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Chronic Cardiac Arrest<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |   |  |                           |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>Chronic Obstructive Pulmonary Disease; Gout; DM  |  |   |  |   |   |  |                           |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                           | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |  |                           |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE<br>SINAI  |   |  |                           |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/27 1984, to 11/13 1984, that (I) (we) lost<br>saw the deceased alive on 11/13 1984 and that (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                |  |   |  |   |   |  |                           |  |   |  |
| 22b. SIGNATURE<br>Francis Caban MD 9/137   |  |   |  | DEGREE  |   |  |                           | 22c. DATE SIGNED<br>11/13/84   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>FRANCIS CABAN MD  |  |   |  | 22e. ADDRESS<br>Sinai Hospital  |   |  |                           |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>11/16/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore, Md                             |                           |  |   |  |
| 24. FUNERAL DIRECTOR<br>Schimunek Funeral Home, Inc.<br>3331 Brehms Lane, Balto., Md. 21212  |  |   |  | 25a. DATE REC'D. BY REGISTRAR AND REGISTRAR'S SIGNATURE<br>NOV 19 1984 Julia Davidson-Randall   |   |  |                           |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 7 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

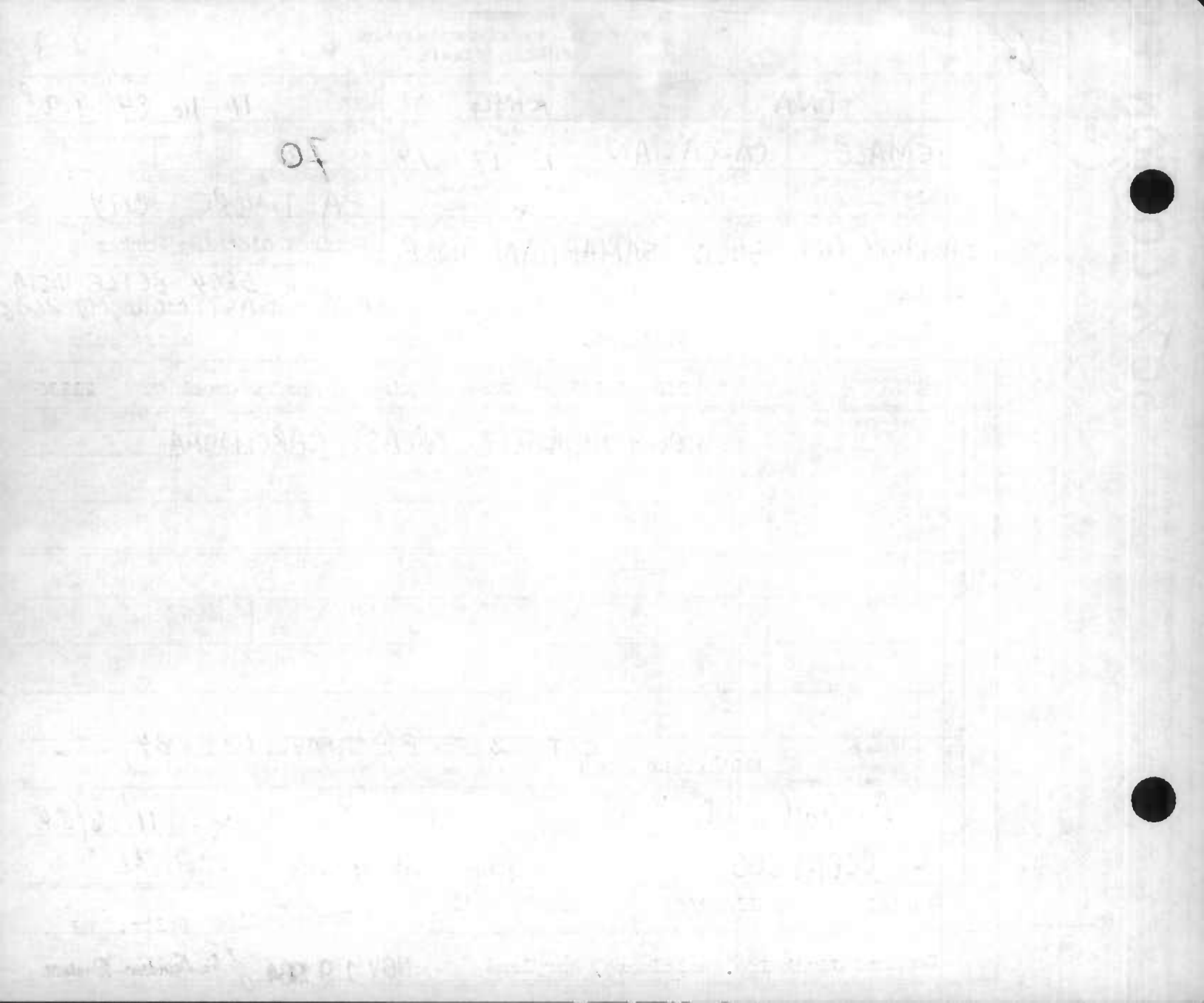
BP

DHMH - 16.50M 1/81  
(VRA 15, 4)

| FOR<br>STATE<br>REGISTRAR   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  | 8 4 3 0 0 0 1<br>REG. NO.   |  |
|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST MIDDLE LAST<br>TINA KING  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>11 16 84  |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>CAUCASIAN  |  | 2b. HOUR<br>9:00 P M  |  |
| 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 17 14   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS   |  | 7b. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Italy  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE MD  |  | 10. CITY OR TOWN OF DEATH<br>BALTIMORE CITY   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>GOOD SAMARITAN HOSP                            |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired clothing worker   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  | 13a. STREET ADDRESS<br>5604-BELLE VISTA AVE - BALTIMORE, MD 21206   |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Francesco Sallustio   |  | 15. MOTHER'S MAIDEN NAME<br>MIDDLE LAST<br>Theresa Mastrangelo  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  |
| 16b. SOCIAL SECURITY NO.<br>213-03-1453   |  | 17. INFORMANT<br>James D King   |  | ADDRESS<br>4 Meadow Creek Ct 21236  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) WIDELY METASTATIC BREAST CARCINOMA<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  | 22a. I certify that (this hospital) attended the deceased from OCT. 2, 19 84, to NOV. 16, 19 84, that (I) saw the deceased alive on NOV. 16, 19 84, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br>L. Ceballos MD  |  |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)<br>L. CEBALLOS  |  | 22d. ADDRESS<br>GOOD SAMARITAN HOSPITAL   |  | 22e. DATE SIGNED<br>11/16/84  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>11/20/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cockeysville Balto. MD  |  | 24. FUNERAL DIRECTOR<br>NAME<br>Leonard JRuck Inc. Baltimore, Maryland  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 19 1984  |  |
| 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |  |   |  |   |  |

MEDICAL CERTIFICATION





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 3 0 0 0 2

REG. NO.

|   |         |   |   |  |  |  |
|---|---------|---|---|--|--|--|
| 1. STATE REGISTRAR  |         | 2a. DATE OF DEATH   |   | 2b. HOUR   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |         | MONTH DAY YEAR  |   | P M  |  |  |
| RALPH F. KINNA  |         | NOVEMBER 19, 1984   |   | 11:29 M  |  |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)   | IF UNDER 1 YEAR  |  |  |
| Male  | White   | MONTH DAY YEAR  | 54  | MONTHS DAYS HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |
| Maryland  |         | U.S.A.  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |
| BALTIMORE   |         | THE JOHNS HOPKINS HOSPITAL  |   | BALTIMORE CITY MD.   |  |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |  |  |
| BALTIMORE   |         | THE JOHNS HOPKINS HOSPITAL  |   | Driver   |  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY   |         | 13a. STREET ADDRESS / ZIP CODE  |   | 13b. INSIDE CITY LIMITS?   |  |  |
| Farm Supply   |         | 5816 Bells Lane, 21701  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |  |
| 14. FATHER'S NAME   |         | 15. MOTHER'S MAIDEN NAME  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)              |  |  |
| FIRST MIDDLE LAST   |         | FIRST MIDDLE LAST   |   | 16b. SOCIAL SECURITY NO.   |  |  |
| Dewey Sampson Kinna   |         | Viola Jane Ramsburg   |   | 220-30-9986  |  |  |
| 17. INFORMANT   |         | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                   |  |  |
| 5816 Bells Lane   |         | IMMEDIATE CAUSE (a) <u>hypertension</u>   |   | 20 min   |  |  |
| Mrs. Ada E. Kinna, Frederick, Md. 21701   |         | DUE TO, OR AS A CONSEQUENCE OF (b) <u>Intracerebral hemorrhage</u>                                    |   | 4 days   |  |  |
|   |         | DUE TO, OR AS A CONSEQUENCE OF (c) <u>Sepsis</u>  |   | 9 days   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |         |   |   |  |  |  |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?  |  |  |
|   |         |   |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |         | 21b. TIME OF INJURY   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |
|   |         | HOUR A.M. MONTH DAY YEAR  |   |  |  |  |
|   |         | P.M. 19   |   |  |  |  |
| 21d. INJURY OCCURRED  |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                   |   | 21f. LOCATION  |  |  |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |         |   |   | CITY OR TOWN COUNTY STATE  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/10</u> , 19 <u>84</u> , to <u>11/19</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>11/19</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |         |   |   |  |  |  |
| 22b. SIGNATURE  |         | DEGREE  |   | 22c. DATE SIGNED   |  |  |
| <u>Edmond Kasper</u>  |         | MD  |   | <u>11/19/84</u>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |         | 22e. ADDRESS  |   | 22f. CITY OR TOWN  |  |  |
| <u>Edmond Kasper</u>  |         | <u>600 N. WOLFE ST. BALTO. MD.</u>  |   | <u>21205</u>   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |         | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |
| Burial  |         | Nov 24, 1984  |   | Mt. Olivet Cemetery  |  |  |
| 24. FUNERAL DIRECTOR  |         | 25a. DATE REC'D. BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE   |  |  |
| <u>Robert C. Basford</u>  |         | <u>NOV 26 1984</u>  |   | <u>John T. Anderson</u>  |  |  |
| 106 East Church Street, Frederick, Md. 21701  |         |   |   |  |  |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please return this certificate to the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician for 10 years after death. Please return this certificate to the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician for 10 years after death. Please return this certificate to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please detach this certificate and return it to the State Department of Health and Mental Hygiene. Please do not detach this certificate from the funeral home. Please do not detach this certificate from the funeral home. Please do not detach this certificate from the funeral home.

IMPORTANT: If item 21 is marked on item 18 showing any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |   |   |  |   |   |  | 8430003                                       |
|---|--|--|---|---|---|--|---|---|--|---|
| 1. FOR REGISTRAR  |  |  |   |   | REG. NO.  |  |   |   |  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ANN OBRIEN KIRCHER</b>   |  |  |   |   | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>30</b> YEAR <b>84</b>   |  |   |   | 2b. HOUR<br><b>9:40am</b>  |   |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH <b>Nov.</b> DAY <b>1</b> YEAR <b>1906</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.                                    |   | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>        |  | IF UNDER 24 HRS<br>HOURS <b></b> MIN. <b></b> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto., Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |   |   |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE CITY</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Homemaker</b> |  |   |
| 13a. STATE<br><b>Md.</b>  |  |  |   |   | 13b. CITY OR TOWN<br><b>Baltimore</b>   |  | 13c. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> |   | 13d. STREET ADDRESS / ZIP CODE<br><b>629 Plymouth Rd., Balto., Md. 21229</b>   |   |
| 14. FATHER'S NAME<br>FIRST <b>Frank</b> MIDDLE <b>C.</b> LAST <b>O'Brien</b>  |  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Frances</b> MIDDLE <b>Beck</b> LAST <b>Md.</b>   |  |   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>218-09-1695</b>   |   | 17. INFORMANT <b>Millersville, Md. 21108</b><br><b>Mr. John E. Kircher, Jr. - 754 N. Mesa Rd.</b>   |   |  |   |   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO-RESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Acute Cardiac Pump Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ACUTE MASSIVE MYOCARDIAL infarction</b>             |  |  |   |   |   |  |   |   |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><b>① Hypertension ②</b>   |  |  |   |   |   |  |   |   |  |   |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |   |   |  | 20a. AUTOPSY?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR (A.M.) MONTH DAY YEAR<br><b>940 P.M. 11-30-1984</b> |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |   |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)          |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-27-1984</b> to <b>11-30-1984</b> , that (I) (we) lost<br>saw the deceased alive on <b>11-30-1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |   |  |   |   |  |   |
| 22b. SIGNATURE<br><b>[Signature]</b>  |  |  |   |   | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input checked="" type="checkbox"/> |  |   | 22c. DATE SIGNED<br><b>11-30-84</b>                   |  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MOHAMED, EL NOUR</b>  |  |  |   |   | 22e. ADDRESS  |  |   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |  |  | 23b. DATE<br><b>12/4/84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cemetery- Baltimore, Md.</b>   |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE            |  |   |
| 24. FUNERAL DIRECTOR<br>NAME <b>Sterling Funeral Estate, P.</b> ADDRESS <b>236 Edmondson Ave.; Catonsville, Md. 21228.</b>  |  |  |   |   | 25. DATE REC'D. BY REGISTRAR <b>DEC 3 1984</b> REGISTERING AGENCY   |  |   |   |  |   |

MEDICAL CERTIFICATION

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8430004

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |   |   |   |  |   |  |
|---|--|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>Cleveland L. Kirkley</u>                                 |  |   | 2a. DATE OF DEATH<br>MONTH <u>11</u> DAY <u>24</u> YEAR <u>1984</u> |   |  | 2b. HOUR<br><u>8:50A.M.</u>   |  |
| 3. SEX<br><u>Male</u>   |  | 4. RACE<br><u>White</u>   |   | 5. DATE OF BIRTH<br>MONTH <u>July</u> DAY <u>29</u> YEAR <u>1910</u>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>74</u>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Baltimore</u>                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Baltimore City</u> MD.                       |  |
| 10. CITY OR TOWN OF DEATH<br><u>Baltimore</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>John L. Deaton Medical Center</u> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Truck Driver</u> |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><u>Retired</u>   |  | 13a. STATE<br><u>Maryland</u>   |   | 13b. COUNTY<br><u>Baltimore</u>   |  | 13c. CITY OR TOWN<br><u>Baltimore</u>   |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><u>1125 William St. 21230</u>   |   |   |  |   |  |
| 14. FATHER'S NAME<br>FIRST <u>Cleveland</u> MIDDLE <u>LeRoy</u> LAST <u>Kirkley</u>             |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <u>Kathleen</u> MIDDLE <u></u> LAST <u></u>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>no</u>               |  | 16b. SOCIAL SECURITY NO.<br><u>213-20-6817</u>  |   | 17. INFORMANT<br>ADDRESS<br><u>James Dyson same as 13</u>   |  |   |  |

11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

cardio respiratory arrestAPPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHConditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

end stage congestive heart failure

DUE TO, OR AS A CONSEQUENCE OF

(c)

arteriosclerotic cardiovascular disease

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.

chronic Renal Failure

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)       |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April 26</u> , 19 <u>84</u> , to <u>November 24</u> , 19 <u>84</u> , that (I) (we) last<br>saw the deceased alive on <u>November 24</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above; (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><u>Yvette Oquendo</u>  |  |  |  | DEGREE<br><u>MD</u>  |  | 22c. DATE SIGNED<br><u>NOV 24 / 1984</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>YVETTE OQUENDO</u>   |  |  |  | 22e. ADDRESS<br><u>611 S. Charles St.<br/>John L. Deaton Med Ctr.</u>                |  |   |  |

|  |  |                                |  |   |  |   |  |
|--|--|--------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Cremation</u> |  | 23b. DATE<br><u>25 Nov. 84</u> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Security Process</u> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Catonsville Balto. MD.</u> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>James S. Kirkley</u>          |  |                                |  | ADDRESS<br><u>Glen Burnie MD.</u>                             |  | 25a. DATE REC'D. BY REGISTRAR<br><u>NOV 27 1984</u>                         |  |
|  |  |                                |  | 25b. REGISTRAR'S SIGNATURE<br><u>Wanda Handall</u>            |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |   |  |   |  |  |
|--|--|--|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>George J. Kirsch  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11-17-84 |   |  | 2b. HOUR<br>M   |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10-3-1916   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS   |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Baltimore  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Good Samaritan Hospital |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>U.S. Govt.                  |  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>Retired   |  |  |   |   |  |   |  |  |
| 13a. STATE<br>Md.  |  | 13b. COUNTY<br>Balto.  |   | 13c. CITY OR TOWN<br>Balto.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 13e. STREET ADDRESS / ZIP CODE<br>5020 Edgar Terrace   |  | 21214  |   |   |  |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Mathias Kirsch   |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Magdalene Grossel  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>Yes WWII   |  | 16b. SOCIAL SECURITY NO.<br>216-01-2210  |   | 17. INFORMANT<br>ADDRESS<br>Mrs. Lois L. Kirsch-5020 Edgar Terrace  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial Infarction<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |   |   |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.<br>Pulmonary Embolism - severe  |  |  |   |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Aug 24, 1984, to Nov 16, 1984, that (I) (we) lost<br>saw the deceased alive on Nov 14, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.          |  |  |   |   |  |   |  |  |
| 22b. SIGNATURE<br>George Bedon   |  | DEGREE<br>MD   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br>11/19/84  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>GEORGE BEDON  |  | 22e. ADDRESS<br>660 Kenilworth Dr. Balto Md.   |   |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>SPECIES<br>Burial   |  | 23b. DATE<br>11-20-84  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley Cem.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cockeysville, Md.                                 |  |  |
| 24. FUNERAL DIRECTOR<br>John C. Miller Inc-6415 Belair Rd.   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 19 1984  |  | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randall   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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11-17-68

Copy to J. Wilson

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8430006

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1- FOR  
STATE  
REGISTRAR

REG. NO.

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|--|--|---|---|---|---------------------------------------|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Ulysses S. Kitt</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 25, 1984</b>   |   |                                       | 2b. HOUR<br>M<br><b>AM</b>   |   |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 4 23</b>  |                                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>60</b> YRS   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.Y.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD   |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>622 E. 29th St.</b> |   |   |                                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. STATE<br><b>MD</b>  |  |   | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b> |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Gertrude Kitt</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>622 E. 29th St. 21218</b>   |   |                                       | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |   |  | 16b. SOCIAL SECURITY NO.<br><b>121-14-6513</b> |  |
| 17. INFORMANT<br>ADDRESS<br><b>Gertrude Kitt 622 E. 29th St.</b>   |  |   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Lung Cancer.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |   |                                       |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)                     |  |   |   |   |                                       |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |                                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>11/20 84</b><br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |                                       |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>Loch Raven V.A.H.</b>   |                                       | 22a. I certify that (I) (this hospital) attended the deceased from <b>11/20 84</b> to <b>11/29 84</b> , that (I) (we) lost saw the deceased alive <b>11/29 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |   |  |  |  |
| 22b. SIGNATURE<br><b>Michael E. Evers MD</b>   |  | DEGREE<br><b>MD</b>   |   |   |                                       | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |   | 22c. DATE SIGNED<br><b>11/28/84</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Michael Evers MD</b>   |  | 22e. ADDRESS<br><b>Loch Raven V.A.H.</b>  |   |   |                                       |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11/30/84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Forest VA</b>   |                                       | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Owings Mills Md</b>   |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>  |  |   |   | ADDRESS<br><b>1101 E. North Ave,</b>  |                                       | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 29 1984</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>J. W. Davidson-Randall</b>  |  |  |

BP

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J

DATE: 10/10/1917

TO: Mr. J. H. ...

FROM: Mr. J. H. ...

SUBJECT: ...

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RE: ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |   |  |
|--|--|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>ELI SWORTH</b> <b>WARREN</b> <b>KLANK</b> <b>KLANK</b>   |  |   |  |   | 2a. DATE OF DEATH MONTH <b>11</b> DAY <b>23</b> YEAR <b>84</b> |  |  |   |  |
| 3. SEX <b>MALE</b>   |  | 4. RACE <b>WHITE</b>  |  | 5. DATE OF BIRTH MONTH <b>OCT.</b> DAY <b>31</b> YEAR <b>1906</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.   |  | 2b. HOUR <b>1:40</b> P.M.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.                               |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FRANCIS SCOTT KEY MED. CTR.</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BARTENDER</b>               |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>BAR &amp; GRILL</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>MARYLAND</b>   |  | 13b. COUNTY <b>BALTO.</b>   |  | 13c. CITY OR TOWN <b>DUNDALK</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS <b>1700 MELBOURNE AVE. 21222</b>  |  |
| 14. FATHER'S NAME FIRST <b>WARREN</b> MIDDLE <b>KLANK</b> LAST <b>KLANK</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST <b>MARIE</b> MIDDLE <b>KLANK</b> LAST <b>KLANK</b>   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>   |  | 16b. SOCIAL SECURITY NO. <b>WW 11 217.03.6727</b>   |  | 17. INFORMANT ADDRESS <b>MARJORIE C. KLANK (WIFE) (SAME AS 13e)</b>   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiovascular collapse</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Probable myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Polyarteritis Nodosa</b>  |  |   |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>minute</b><br><b>minute</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)<br><b>Polyarteritis Nodosa</b>  |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION <b>11/23</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>about 11/23</b> to <b>11/23</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>11/23</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE <b>John R. Brooks</b>   |  | DEGREE  |  | 22c. DATE SIGNED <b>11/23/84</b>  |  |  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John R. Brooks</b>  |  | 22e. ADDRESS <b>5200 EASTON AVE BALD 21224</b>  |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>   |  | 23b. DATE <b>11/26/1984</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>GREEN MOUNT CREMATORY</b>   |  | 23d. LOCATION CITY OR TOWN <b>BALTIMORE</b> COUNTY <b>MARYLAND</b> STATE <b>MARYLAND</b>     |  |   |  |
| 24. FUNERAL DIRECTOR <b>WALTER BROOKS BRADLEY INC., DUNDALK, MD. 21222</b>   |  |   |  | 25. DATE RECEIVED BY REGISTRAR <b>NOV 26 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Walter Brooks Bradley</b>                                      |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND   |  |   |  |   |   |   |                              |  |  |
|---|--|---|--|---|---|---|------------------------------|--|--|
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |   |   |                              |  |  |
| CERTIFICATE OF DEATH  |  |   |  |   |   |   |                              |  |  |
| REG. NO. 84 30008   |  |   |  |   |   |   |                              |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>ROBERT ALVIN KLEMM</b>   |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>NOVEMBER 6, 1984</b> |   | 2b. HOUR<br><b>3:05 P.M.</b> |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>01 22 28</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY) YRS<br><b>56</b>                                    |                              | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                   |                              |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSPITAL</b> |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>TRANSCRIPTS</b> |                              | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>SHIP LINES</b>   |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>---</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 13c. STREET ADDRESS<br><b>303 S. FURROW STREET, 21223</b>                           |                              |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>ALBERT KLEMM</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>ELIZABETH K. MUENZING</b>  |   |   |                              |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>YES</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>WW II 218-22-6656</b>  |  | 17. INFORMANT ADDRESS<br><b>EARL C. KLEMM 522 FOUNTAIN DRIVE 21090</b>  |   |   |                              |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ASPIRATION PNEUMONITIS</b>  |  |   |  |   |   |   |                              |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>CARCINOMATOSIS</b>   |  |   |  |   |   |   |                              |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |   |  |   |   |   |                              |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  |  |   |  |   |   |   |                              |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)  |   |   |                              |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |   |                              |  |  |
| 22a. I certify that (this hospital) attended the deceased from <b>Nov. 5, 1984</b> to <b>Nov. 6, 1984</b> , that (we) last saw the deceased alive on <b>Nov. 6, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |   |   |                              |  |  |
| 22b. SIGNATURE<br><b>Bert F. Morton</b>   |  |   |  | DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |   |                              | 22c. DATE SIGNED<br><b>11/7/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BERT F. MORTON</b>  |  |   |  | 22e. ADDRESS<br><b>ST. AGNES HOSPITAL CATON AVE</b>   |   |   |                              |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>11-10-84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK</b>  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTIMORE CITY MARYLAND</b>           |                              |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>HUBBARD FUNERAL HOME, INC.</b>  |  |   |  | ADDRESS<br><b>4107 WILKENS AVE.</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 9 1984</b>                                  |                              | 25b. REGISTRAR'S SIGNATURE<br><i>Davidson</i>  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
1 - STATE  
REGISTRAR

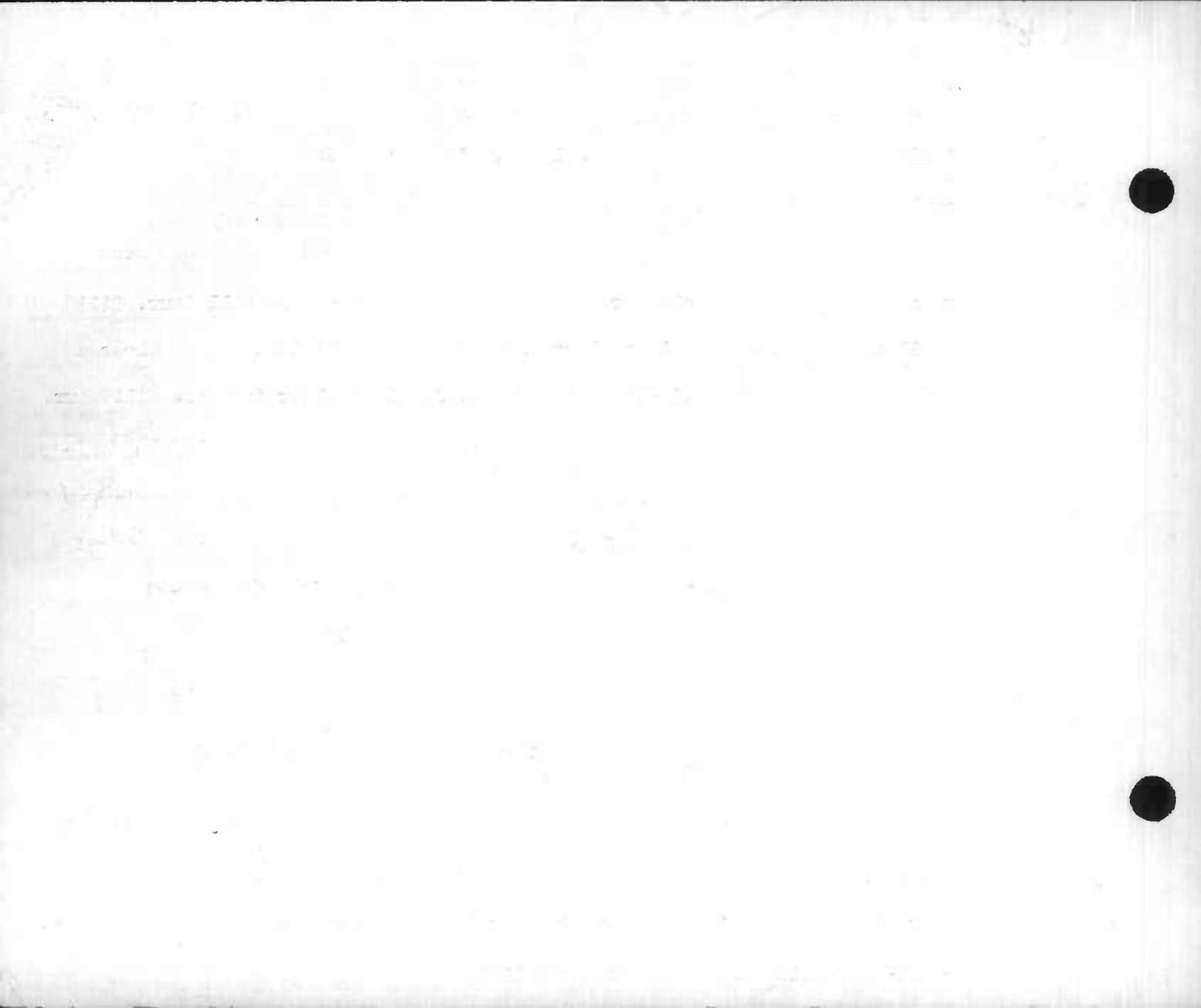
REG. NO.

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>JAMES Bosson KLINEFELTER  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 9 84 |   |  | 2b. HOUR<br>1:45 P.M.   |   |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>July 30, 1916   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>None  |   |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>None  |  | 13a. STREET ADDRESS / ZIP CODE<br>506 Rose Hill Terr. 21218  |  |   |  |   |   |
| 13b. COUNTY<br>Maryland  |  | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE<br>506 Rose Hill Terr. 21218   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William J. Klinefelter   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Jennie Fielding Bosson   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>219-76-5022  |  | 17. INFORMANT<br>ADDRESS<br>Mr. Wm. J. Klinefelter 506 Rose Hill Terr.  |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Aspiration</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>SIP @ CVA</u>   |  |  |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>Immed - 10 min</u><br><u>Immed - 4</u><br><u>5 days</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Total obtundation and immobility 29 to CVA</u>   |  |  |  |   |  |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/5/84</u> 19 to <u>11/9/84</u> 19, that (I) (we) last saw the deceased alive on <u>11/9/84</u> 19, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |   |
| 22b. SIGNATURE<br>J. Wells MD  |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br>11/9/84   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. J. WELLS  |  |  |  | 22e. ADDRESS<br>UNION MEMORIAL HOSPITAL   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>11-13-84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.   |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Mitchell-Wiedefeld Home 6500 York Road 21212   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 13 1984  |  | 25b. REGISTRAR'S SIGNATURE<br>Lila Davidson-Rendell   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Bureau of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2, 4, and 5 and file them with the funeral director. Page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. Page 4 and 5 should be filed within 72 hours of death. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the examiner must be notified of once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

84

REG. NO.

30010

|  |                                   |  |                            |  |   |  |  |
|--|-----------------------------------|--|----------------------------|--|---|--|--|
| 1. FOR STATE REGISTRAR   |                                   | 2a. DATE OF DEATH  |                            | MONTH  | DAY   | YEAR   | 2b. HOUR   |
| DECEASED NAME (TYPE OR PRINT)  |                                   | FIRST  |                            | MIDDLE   | LAST  |  |  |
| MARY   |                                   | E  |                            | KMOCH  |   | 11 22 84 4:15PM                                    |  |
| 3. SEX   | F                                 | 4. RACE  | WHITE                      |  | 5. DATE OF BIRTH  | AUG. 2, 1911                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | MD.                               | 7b. CITIZEN OF WHAT COUNTRY?   | U.S.A.                     |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | 73 YRS.  |  |
| 10. CITY OR TOWN OF DEATH  | BALTIMORE                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | THE JOHNS HOPKINS HOSPITAL |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                | BALTIMORE CITY MD.                                 |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  | 12b. KIND OF BUSINESS OR INDUSTRY |  | HOUSEWIFE                  |  |   |  |  |
| 13a. STATE   | MD.                               | 13b. COUNTY  | BALTO.                     |  | 13c. STREET ADDRESS / ZIP CODE                                      | 1015 S. ELLWOOD AVE. 21224                         |  |
| 14. FATHER'S NAME  | FIRST                             | MIDDLE   | LAST                       | 15. MOTHER'S MAIDEN NAME   | FIRST   | MIDDLE   | LAST   |
| FRANK  | FRANCIS Z KOWSKI                  |  | EVA                        | KACZMARCZYK  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  | 16b. SOCIAL SECURITY NO.          |  | 17. INFORMANT              |  | ADDRESS   |  |  |
| NO   | 212-09-2872                       |  | STEPHEN P. KMOCH           |  | 1015 S. ELLWOOD AVE. 21224  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>BRAIN ANOXIA</u>   |                                   |  |                            |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>3 minutes</u> |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>CARDIO RESPIRATORY ARREST</u>   |                                   |  |                            |  |   |  | <u>10 minutes</u>  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>DISSEMINATED METASTATIC BREAST CARCINOMA</u>  |                                   |  |                            |  |   |  | <u>about 1 year</u>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><u>UTI Sepsis / Atrial Fibrillation / Anoxia / Thrombocytopenia - Leucopenia</u>   |                                   |  |                            |  |   |  |  |
| 19a. DATE OF OPERATION   |                                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                            |  | 19c. AUTOPSY?   |  | 19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |
|  |                                   |  |                            |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>         |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                   | 20b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                            | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |  |  |
| 20d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                                   | 20e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                 |                            | 20f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |  |
|  |                                   |  |                            |  |   |  |  |
| 21. I certify that (a) (this hospital) attended the deceased from <u>11/15</u> , 19 <u>84</u> , to <u>11/22</u> , 19 <u>84</u> , that (we) last saw the deceased alive on <u>11/22</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                                   |  |                            |  |   |  |  |
| 22a. SIGNATURE<br><u>Andrew Gordon</u>   |                                   |  |                            | DEGREE<br>MD   |   | 22c. DATE SIGNED<br>11/22/84                       |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Andrew Gordon   |                                   |  |                            | 22d. ADDRESS<br>THOC 600 N. Wolfe St Balt. Md 21205                            |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (OTHER)  |                                   | 23b. DATE  |                            | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE         |  |
| BURIAL   |                                   | 11-26-84   |                            | SAC HEART OF MARY  |   | BALTO CO MD  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>THOMAS J. SKARDA 2829 HODSON ST.   |                                   |  |                            | 25a. DATE REC'D BY REGISTRAR<br>NOV 26 1984                                    |   | 25b. REGISTRAR'S SIGNATURE<br><u>Andrew Gordon</u> |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, pages 1 and 2, and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 84 30011<br>REG. NO.   |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>FRANK C. KNAPIK</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>11 25 84</b>   |  |  |  |
| 3 SEX <b>MALE</b>  |  |  |  | 4 RACE <b>W</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>July 26, 1893</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH <b>BALTO.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Francis Scott Key M.C.</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CITY WORKER</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>CEMENT FW.</b>  |  |
| 13a. STATE <b>MD.</b>  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN <b>BALTO.</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                           |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Josef KNAPIK</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>  |  | 13a. STREET ADDRESS <b>2224 226 S. Eaton Street</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>214-40-5628</b>  |  | 17. INFORMANT ADDRESS <b>Miss Dolores Knapik 226 S. Eaton St. 21224</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>HEMISPHT. CEREBROVASCULAR ACCIDENT</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSE OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>NOV 9</b> , 19 <b>84</b> , to <b>NOV 25</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>NOVEMBER 25</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE <b>Mitchell J. Cohen</b> DEGREE <b>M.D.</b>   |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED <b>11/25/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MITCHELL J. COHEN</b>   |  |  |  | 22e. ADDRESS <b>4940 EASTERN AVE. BALTO, MD.</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |  | 23b. DATE <b>11-27-1984</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Holy ROSARY Cem.</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD.</b>  |  |
| 24. FUNERAL DIRECTOR NAME <b>Joseph N. ZANNINO JR</b> ADDRESS <b>263 S. Conkling St. 21224</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>NOV 27 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>   |  |

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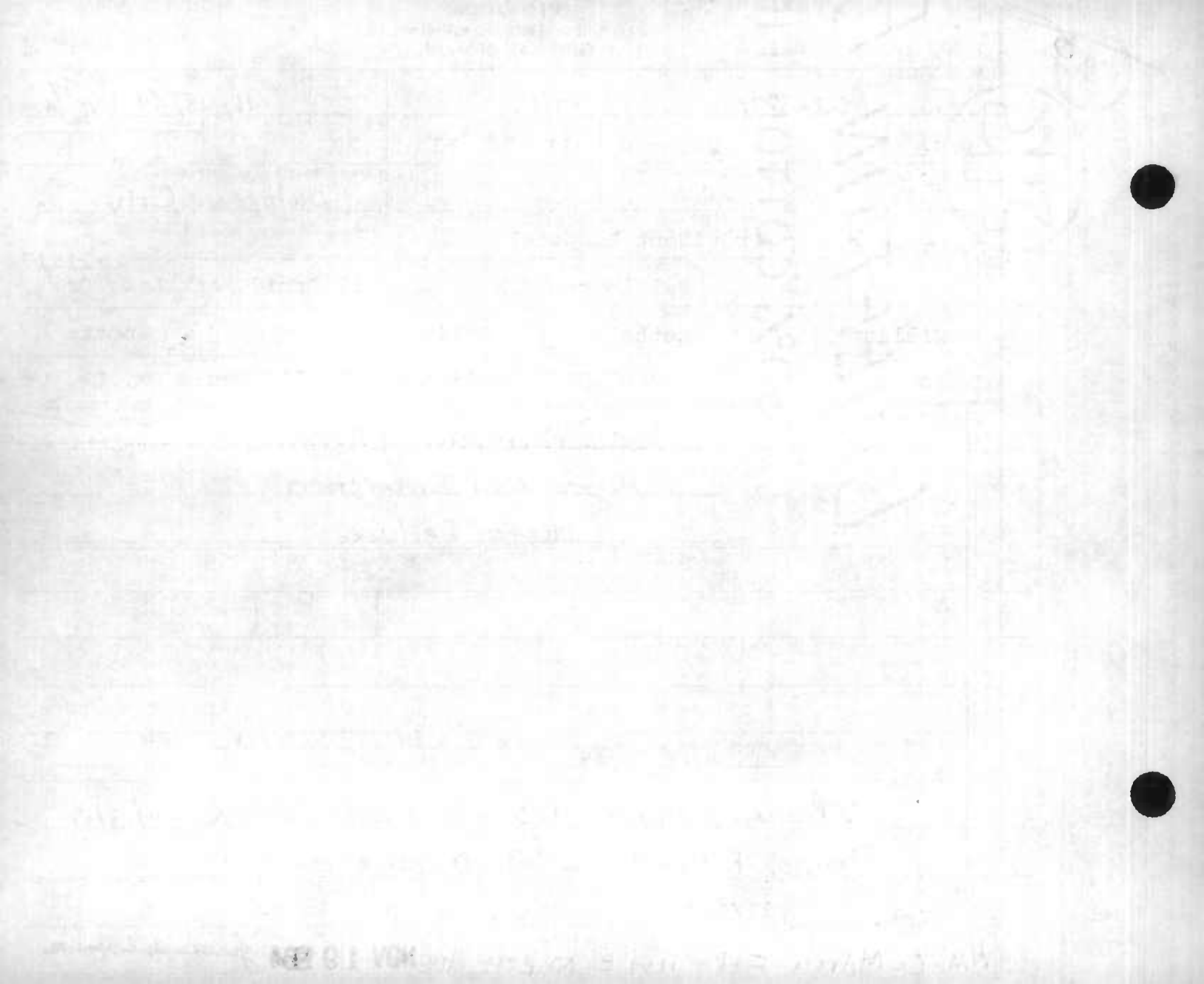
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |   |   |  |  |  |   |   | REG. NO. 8430012 |  |
|---|--|---|---|---|--|--|--|---|---|------------------|--|
| 1. FOR STATE REGISTRAR  |  |   |   |   |  |  |  |   |   |                  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><i>Roosevelt Knotts</i>   |  |   |   |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>11/18/84</i>  |  |   | 2b. HOUR<br><i>6:17 A.M.</i>  |                  |  |
| 3 SEX<br><i>Male</i>  |  | 4 RACE<br><i>Black</i>  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>11 24 13</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>70</i>   |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN.   |   |                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>N.C.</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                            |  |   |   |                  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Provident Hospital</i> |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY                           |   |                  |  |
| 13a. STATE<br><i>MD</i>   |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><i>Baltimore</i>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>717 Druid Park Lake Dr.</i>       |   |                  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>William Knotts</i>  |  |   |   | 15. MOTHER'S MAIDEN NAME MIDDLE<br><i>Julia Knotts</i>  |  |  |  |   |   |                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>NO</i>   |  |   |   | 16b. SOCIAL SECURITY NO.<br><i>218-07-9174</i>  |  | 17. INFORMANT ADDRESS<br><i>Pauline Knotts 717 Druid Pk. Lk. Dr.</i>                         |  |   |   |                  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardio Pulmonary Arrest</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Myocardial Infarction</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>Renal Failure</i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |   |   |  |  |  |   |   |                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>a</i>   |  |   |   |   |  |  |  |   |   |                  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)   |  |  |   |   |                  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |   |   |                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11/18</i> , 19 <i>84</i> , to <i>11/18</i> , 19 <i>84</i> , that (I) (we) lost saw the deceased alive on <i>11/18</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |  |  |   |   |                  |  |
| 22b. SIGNATURE<br><i>Eleanor Y. Hixon, MD</i>   |  |   | DEGREE<br><i>MD</i>   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  |   | 22c. DATE SIGNED<br><i>11/18/84</i>   |                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Eleanor Y. Hixon, MD</i>  |  |   | 22e. ADDRESS<br><i>3100 Towanda Ave.</i>                            |   |  |  |  |   |   |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>  |  |   | 23b. DATE<br><i>11/23/84</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Md. Nat'l Mem. Pk.</i>  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>Laurel MD</i> |   |                  |  |
| 24. FUNERAL DIRECTOR NAME<br><i>Wm. C. March F.H.</i>   |  |   | ADDRESS<br><i>1101 E. NORTH AVE</i>                                 |   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>NOV 19 1984</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson</i>         |   |                  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the instructions on the reverse, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |               |   |                   |  |                |   |
|---|--|---|--|---|---------------|---|-------------------|--|----------------|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST SUTTON  |  | MIDDLE NMN  | LAST KNUCKLES |   | 2a. DATE OF DEATH |  | MONTH DAY YEAR | 2b. HOUR  |
| SUTTON  |  | KNUCKLES  |  |   |               | 11 22 84  |                   | 1:45 AM  |                |   |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |               | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |                   | IF UNDER 1 YEAR  |                | IF UNDER 24 HRS                                 |
| MALE  |  | WHITE   |  | 1 11 1919   |               | 65 64 YRS.  |                   | MONTHS DAYS  |                | HOURS MIN.                                      |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |               | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                   |  |                |   |
| VIRGINIA  |  | U.S.A.  |  |   |               | Baltimore City MD.  |                   |  |                |   |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |               | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |                   | 12b. KIND OF BUSINESS OR INDUSTRY                              |                |   |
| Baltimore City  |  | Good Samaritan Hospital   |  |   |               | Welder  |                   | Beth. Steel  |                |   |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |               |   |                   |  |                |   |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |               | 13d. INSIDE CITY LIMITS?  |                   | 13e. STREET ADDRESS  |                |   |
| MD  |  | Baltimore   |  | Parkville   |               | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                   | 3324 Willoughby Rd. 21234                                      |                |   |
| 14. FATHER'S NAME   |  |   |  | 15. MOTHER'S MAIDEN NAME  |               |   |                   |  |                |   |
| FIRST James   |  | MIDDLE Bowman   |  | LAST Knuckles   |               | FIRST Daisy   |                   | MIDDLE NMN   |                | LAST Johns                                      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT   |               | ADDRESS   |                   |  |                |   |
| No  |  | N/A   |  | 218/12/0888   |               | (Sister)  |                   | 709 Edgewood Rd. 21090   |                |   |
|   |  |   |  |   |               | Mrs. Lucille Killian Linthicum Heights, Md                          |                   |  |                |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardio Pulmonary arrest   |  |   |  |   |               |   |                   |  |                | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) Malignant Mesothelioma  |  |   |  |   |               |   |                   |  |                |   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |   |  |   |               |   |                   |  |                |   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |  |   |               |   |                   |  |                |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |               |   |                   |  |                |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |               | 20a. AUTOPSY?   |                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                |   |
|   |  |   |  |   |               | YES <input type="checkbox"/> NO <input type="checkbox"/>            |                   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |               |   |                   |  |                |   |
|   |  | P.M. 19   |  |   |               |   |                   |  |                |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET   |               | CITY OR TOWN  |                   | COUNTY   |                | STATE   |
|   |  |   |  |   |               |   |                   |  |                |   |
| 22a. I certify that (1) (the hospital) attended the deceased from 11-20, 19 84, to 11-21, 19 84, that (1) (the) lost saw the deceased alive on 11-21, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. |  |   |  |   |               |   |                   |  |                |   |
| 22b. SIGNATURE  |  |   |  | DEGREE  |               |   |                   | 22c. DATE SIGNED   |                |   |
| Rosita R. Cruz M.D.   |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |               |   |                   | 11-22-84   |                |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  | 22e. ADDRESS  |               |   |                   |  |                |   |
| ROSITA R. CRUZ M.D.   |  |   |  | GOOD SAMARITAN HOSPITAL   |               |   |                   |  |                |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |               | 23d. LOCATION<br>CITY OR TOWN                                       |                   | COUNTY   |                | STATE   |
| Burial  |  | Nov. 26, 1984   |  | Glen Haven Mem. Park  |               | Glen Burnie   |                   | A.A.   |                | MD.   |
| 24. FUNERAL DIRECTOR<br>NAME  |  |   |  | ADDRESS   |               |   |                   | 25a. DATE REC'D. BY REGISTRAR                                  |                | 25b. REGISTRAR'S SIGNATURE                      |
| Singleton Funeral Home  |  |   |  | Glen Burnie, Md.  |               |   |                   | NOV 27 1984  |                | Handell   |

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8430014  
REG. NO.FOR  
STATE  
REGISTRAR

|  |  |  |   |  |                                   |   |  |
|--|--|--|---|--|-----------------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MIDDLE LAST  |   | 2a. DATE OF DEATH MONTH DAY YEAR   |                                   | 2b. HOUR  |  |
| MARGARET KOERBER   |  | A. Koerber   |   | 11/20/1984   |                                   | 10:08A  |  |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH MONTH DAY YEAR  |   | 6. AGE (IN YEARS LAST BIRTHDAY)  |                                   | 7. IF UNDER 1 YEAR IF UNDER 24 HRS                                  |  |
| Female   | White  | 4 10 98  |   | 86 YRS   |                                   | MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                                   |   |  |
| N.J.   | U. S. A.   |  |   | Baltimore City MD.   |                                   |   |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |
| Balto.   | St. Agnes Hospital   |  | Seamstress-Lion Bros.   |  |                                   |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b. CITY OR TOWN  |   | 13c. STREET ADDRESS / ZIP CODE   |                                   | 13d. INSIDE CITY LIMITS?  |  |
| Md. Balto.   |  |  |   | 6800 Lenbern Rd. #21207  |                                   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                       |                                   |   |  |
| Mary Vadas   |  | Stephen  |   | 16b. SOCIAL SECURITY NO. 218-09-4236   |                                   |   |  |
| 17. INFORMANT  |  | 17. ADDRESS  |   | 17. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                   |   |  |
| Louis A. Letrichet   |  | 6800 Lenbern Rd.-Balto., Md.   |   | #21207   |                                   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |   |  |                                   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:   |  |  |   |  |                                   |   |  |
| IMMEDIATE CAUSE (a) Cardiovascular collapse  |  |  |   |  |                                   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |   |  |                                   |   |  |
| (b) Sepsis   |  |  |   |  |                                   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |   |  |                                   |   |  |
| (c) leg gangrenous ulcer   |  |  |   |  |                                   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |  |   |  |                                   |   |  |
| Peripheral vascular occlusive disease  |  |  |   |  |                                   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?  |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
| 11/19/84   |  | Gangrenous ulcer @ leg   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                    |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                         |                                   |   |  |
|  |  | P.M. 19  |   |  |                                   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)   |   | 21f. LOCATION CITY OR TOWN COUNTY STATE  |                                   |   |  |
|  |  |  |   |  |                                   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/8, 19 84, to 11/20, 19 84, that (I) (we) last saw the deceased alive on 11/20, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |                                   |   |  |
| 22b. SIGNATURE   |  | DEGREE   |   | 22c. DATE SIGNED   |                                   |   |  |
| Caryn C. Wunderlich MD   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |   | 11/20/84   |                                   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |   |  |                                   |   |  |
| Caryn C. Wunderlich  |  | 900 Caton Ave. Baltimore   |   |  |                                   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |                                   | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |  |
| Burial   |  | 11-23-84   |   | New Cathedral Cem.   |                                   | Balto. Md.  |  |
| 24. FUNERAL DIRECTOR   |  | 24. ADDRESS  |   | 25a. DATE REC'D. BY REGISTRAR  |                                   | 25b. REGISTRAR'S SIGNATURE  |  |
| G. Edman Schwab  |  | 5151 Balto. Nat'l. Pike #21229   |   | NOV 28 1984  |                                   | Cora Davidson Handell   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner should be notified directly.



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8430015  
REG. NO.

|  |   |   |   |   |                                   |
|--|---|---|---|---|-----------------------------------|
| 1. FOR<br>STATE<br>REGISTRAR   |   | 2a. DATE OF DEATH   |   | 2b. HOUR  |                                   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Janet R. Koons   |   | MONTH DAY YEAR<br>11 25 84  |   | 8 P M   |                                   |
| 3. SEX<br>Female   | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>aug. 15 1902  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS.  |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>       |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |                                   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1138 E. Northern Pkwy. 21239 |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker |   | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |   | 13b. COUNTY   | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Andrew Shepard Cross   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna Rebecca DuVal   |   |   |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no   |   | 16b. SOCIAL SECURITY NO.<br>215-50-6339   |   | 17. INFORMANT<br>ADDRESS<br>21230 Dr. L. Kemper Owens 1033 Apt. E Malcolm Cir.                  |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arteriosclerotic Cerebrovascular Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Immediate</u><br><u>years</u> |   |   |   |   |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.  |   |   |   |   |                                   |
| 19a. DATE OF OPERATION<br><u>None</u>  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |   |   |   |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                   |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>June 19 84</u> to <u>11-25 19 84</u> , that (I) (we) last saw the deceased alive on <u>11-23 19 84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |   |   |   |                                   |
| 22b. SIGNATURE<br><u>Dr. L. Kemper Owens</u>   |   | DEGREE<br><u>MD</u><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><u>11-26-84</u>   |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. L. Kemper Owens   |   | 22e. ADDRESS<br><u>300 Armonoy Place (3rd)</u><br><u>Baltimore, Md. 21201</u>   |   |   |                                   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation  |   | 23b. DATE<br>11/27/84   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Greenmount Cemetery                                       |                                   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.  |   |   |   |   |                                   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Mitchell-Wiedefeld   |   | ADDRESS<br>6500 York Rd.  |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 27 1984  |                                   |
|  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Gelia Davidson-Randall</u>   |   |   |                                   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



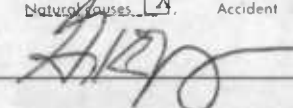
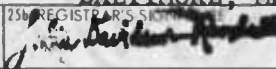


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DHMH - 17  
(VR A15 ME (5))  
20M 4/B2

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |               |  |   |  |   |  |  |  | REG. NO. 310016   |  |
|--|--|---------------|--|---|--|---|--|--|--|---|--|
| 1- FOR STATE REGISTRAR UNKN. 84-86   |  |               |  |   |  |   |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 11/12/84 |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Steve J. Koporec  |  |               |  |   |  |   |  |  |  | 2b. HOUR 12:40 P M  |  |
| 3. SEX MALE  |  | 4. RACE CAUC. |  | 5. DATE OF BIRTH MONTH DAY YEAR 06 06 1912  |  | 6. AGE (IN YEARS) (LAST BIRTHDAY) 72 YRS.               |  | 7c. DATE PRONOUNCED DEAD 11/12/84  |  | 7d. HOUR 12:40 P M  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND   |  |               |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  |
| 10. CITY OR TOWN OF DEATH Baltimore  |  |               |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1319 Dundalk Ave. (front) |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) VARIOUS JOBS   |  |   |  |
| 13a. STATE MARYLAND  |  |               |  | 13b. COUNTY   |  | 13c. CITY OR TOWN BALTIMORE                             |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST STEVE - KOPOREC  |  |               |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY - BRABLIC   |  |   |  | 13e. STREET ADDRESS 1403 BETHLEHEM AVENUE 21222  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO  |  |               |  | 16b. SOCIAL SECURITY NO. 213-07-7517  |  |   |  | 17. INFORMANT ADDRESS FRANK KOPOREC - 1403 BETHLEHEM AVE. 21222  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |               |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:  |  |               |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |               |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |               |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |               |  |   |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE    |  |               |  | TITLE (SPECIFY) M.D. Assistant  |  |   |  | MEDICAL EXAMINER DATE SIGNED 11/13/84  |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D.  |  |               |  | ADDRESS 111 Penn St.  |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL   |  |               |  | 23b. DATE 11/16/84  |  | 23c. NAME OF CEMETERY OR CREMATORY SACRED HEART OF MARY |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MD.                              |  |
| 24. FUNERAL DIRECTOR NAME WALTER DABROWSKI - 1005 DUNDALK AVE, #2  |  |               |  | 25a. DATE REC'D. BY REGISTRAR NOV 19 1984   |  |   |  | 25b. REGISTRAR'S SIGNATURE    |  |   |  |

DATE: 06-01-73

U.S.A.

AMERICAN LEGATION

1000 BELLEVUE AVENUE, WASHINGTON, D.C. 20003

STEVE ROYBARK - 1000 BELLEVUE AVENUE, WASHINGTON, D.C. 20003

212-07-7-17

1000 BELLEVUE AVENUE, WASHINGTON, D.C. 20003

WASHINGTON, D.C.

RECEIVED

DATE

WALTER BURNS - 1000 BELLEVUE AVENUE, WASHINGTON, D.C. 20003

# DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

3 0 0 1 7

|  |              |                                    |                                    |  |  |  |  |  |  |  |  |
|--|--------------|------------------------------------|------------------------------------|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |              |                                    |                                    | 2a. DATE KNOWN OF DEATH  |  |  |  | 2b. HOUR   |  |  |  |
| FIRST MIDDLE LAST<br><b>ANDREW Alan KOSMIDES</b>   |              |                                    |                                    | MONTH DAY YEAR<br><b>11-19-84</b>  |  |  |  | M<br><b>4:15A</b>  |  |  |  |
| 3. SEX   | 4. RACE      | 5. DATE OF BIRTH<br>MONTH DAY YEAR | 6. AGE (IN YEARS)<br>LAST BIRTHDAY | 7. IF UNDER 1 YR.<br>MONTHS DAYS   |  | 7. IF UNDER 24 HRS.<br>HOURS MIN.                        |  | 2c. DATE PRONOUNCED DEAD   |  | 2d. HOUR                                     |  |
| <b>male</b>  | <b>white</b> | <b>July 17, 1963</b>               | <b>21 YRS.</b>                     |  |  |  |  | <b>11-19-84</b>  |  | <b>4:15A</b>                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |              |                                    |                                    | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |
| <b>Annapolis, Md.</b>  |              |                                    |                                    | <b>U.S.A.</b>  |  |  |  | <b>Baltimore City</b>  |  |  |  |
| 14. CITY OR TOWN OF DEATH  |              |                                    |                                    | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  |  |
| <b>Baltimore</b>   |              |                                    |                                    | <b>University Hospital STU</b>   |  |  |  | <b>carpenter</b>   |  |  |  |
| 13a. STATE   |              |                                    |                                    | 13b. CITY OR TOWN  |  |  |  | 13c. STREET ADDRESS  |  |  |  |
| <b>Md.</b>   |              |                                    |                                    | <b>A.A. Co.</b>  |  |  |  | <b>104 Conduit St.</b>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |              |                                    |                                    | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |  |  |  | 16. ADDRESS  |  |  |  |
| <b>George A. Kosmides</b>  |              |                                    |                                    | <b>Mary T. Lynch</b>   |  |  |  | <b>304 Melvin Ave.</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |              |                                    |                                    | 16b. SOCIAL SECURITY NO.   |  |  |  | 17. INFORMANT  |  |  |  |
| <b>no</b>  |              |                                    |                                    | <b>217-80-8492</b>   |  |  |  | <b>George A. Kosmides Ann. Md. 21401</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:   |              |                                    |                                    |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a) <b>Gunshot wound of head</b>   |              |                                    |                                    |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |              |                                    |                                    |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:  |              |                                    |                                    |  |  |  |  |  |  |  |  |
| (b) <b>DUE TO, OR AS A CONSEQUENCE OF</b>  |              |                                    |                                    |  |  |  |  |  |  |  |  |
| (c)  |              |                                    |                                    |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |              |                                    |                                    |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |              |                                    |                                    | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  | 20. AUTOPSY?   |  |  |  |
|  |              |                                    |                                    |  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |              |                                    |                                    | 21b. TIME OF INJURY<br><b>2:10AM 11-19-84</b>  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |
|  |              |                                    |                                    | <b>P.M. 19</b>   |  |  |  | <b>self/inflicted</b>  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |              |                                    |                                    | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |  |  | 21f. LOCATION  |  |  |  |
|  |              |                                    |                                    | <b>at pier of end of</b>   |  |  |  | <b>Conduist street</b>   |  |  |  |
|  |              |                                    |                                    | CITY OR TOWN   |  |  |  | STATE  |  |  |  |
|  |              |                                    |                                    | <b>Annapolis, Md.</b>  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |              |                                    |                                    |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Margarita A. Korell</b>  |              |                                    |                                    |  |  | TITLE (SPECIFY) <b>Assistant</b>                         |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>   |              |                                    |                                    |  |  | ADDRESS <b>111 Penn Street</b>                           |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |              |                                    |                                    | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY                       |  |  |  | 23d. LOCATION                                |  |
| <b>Burial</b>  |              |                                    |                                    | <b>11/21/84</b>  |  | <b>Hillcrest Cemetery</b>                                |  |  |  | <b>Annapolis A.A.Co. Md.</b>                 |  |
| 24. FUNERAL DIRECTOR NAME  |              |                                    |                                    |  |  | 25a. DATE REC'D. BY REGISTRAR                            |  |  |  |  |  |
| <b>Hardesty Funeral Home</b>   |              |                                    |                                    |  |  | <b>NOV 20 1984</b>                                       |  |  |  |  |  |
| ADDRESS <b>12 Ridgely Ave. Ann. Md. 21401</b>  |              |                                    |                                    |  |  | 25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randell</b> |  |  |  |  |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

100% COTTON FIBER

MAINTAIN

WASH



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 4 3 0 0 1 8  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |  |   |
|---|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MAMIE Barbana KOSTERINK</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11 19 84</b>   |  | 2b. HOUR<br><b>7:45 AM</b>                            |
| 3. SEX<br><b>FEMALE</b>   | 4. RACE<br><b>CAUCASIAN</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>05 07 07</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>South Baltimore General Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Housewife</b> |
| 13a. STATE<br><b>Maryland</b>   | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>21225</b><br><b>213 SEWARD AVENUE</b>                               |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John NOCAR</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARIE VANICEK</b><br><b>VANICEK</b>   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b> |  | 16b. SOCIAL SECURITY NO.<br><b>217-20-1798</b>  |   | 17. INFORMANT<br><b>Hospital</b><br><b>1522 Filbert St. Balto. 21226</b><br><b>Chant Mildred Lurskis</b> |   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**Respiratory Arrest**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**minutes**

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b) **Metastatic Adenocarc.****3 months**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Adenocarcinoma colon****6 months**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

**None**

|   |  |  |  |  |   |
|---|--|--|--|--|---|
| 19a. DATE OF OPERATION<br><b>10-18-84</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Partial Bowel obstruction</b> |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10 Nov 84 1980</b> to <b>present</b> , that (I) (we) just saw the deceased alive on <b>10 Nov 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |
| 22b. SIGNATURE<br><b>S. R. G. B. D. E. P.</b>   |  | DEGREE   |  | 22c. DATE SIGNED<br><b>15 Nov 84</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>S. R. G. B. D. E. P.</b>  |  | 22e. ADDRESS<br><b>4200 Pennington Ave. Balto 21226</b>                              |  |  |   |

|   |                                |  |  |
|---|--------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>       | 23b. DATE<br><b>11/23/1984</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Cross Cemetery</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, A. A. Co., Md.</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>McGully Funeral Homes</b>        |                                | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 23 1984</b>              |  |
| ADDRESS<br><b>Balto., Md., 21226</b><br><b>4200 Pennington Ave.</b> |                                | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                 |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE **8 4 3 0 0 1 9**  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

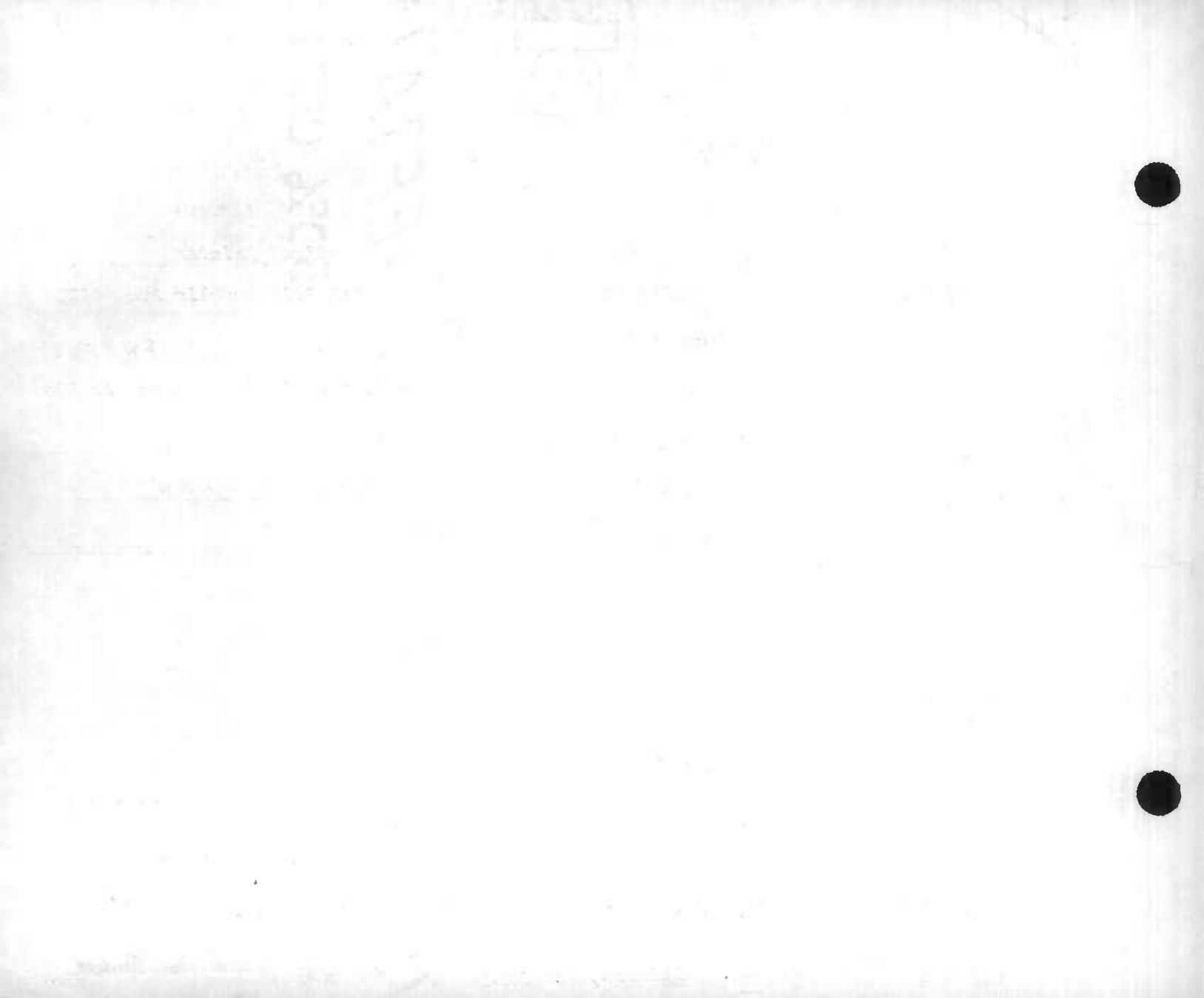
|   |  |   |  |   |  |  |   |  |  |
|---|--|---|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>PETROS J Koutsoutis</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 17 84</b>                 |   | 2b. HOUR<br><b>11: AM</b>  |  |   |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 26 96</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b> YRS<br>MONTHS DAYS HOURS MIN.   |   |  |  |
| 7a. BIRTHPLACE<br>(COUNTRY)<br><b>GREECE</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Meridian Hamilton Nsc. Center</b> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired Painter</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY                 |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 13e. STREET ADDRESS / ZIP CODE<br><b>282 2818 Rosalie Ave 21234</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN Koutsoutis</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>STAMATOULA SAFFOS</b>   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF KNOWN, GIVE YEAR OR DATES)<br><b>317-09-1796</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs Stamatoula Koutsoutis Same As 13e</b>  |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO-PULMONARY ARREST.</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>SUSPECTED CARCINOMA, SITE UNKNOWN</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>COPD. EMPHYSEMA.</b> |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH      |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a  |  |   |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)             |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost<br>saw the deceased alive on <b>11/15/84</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>C. E. PARRA M.D.</b>   |  |   | DEGREE   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>11/17/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>C. E. PARRA</b>   |  |   | 22e. ADDRESS<br><b>7122 HARFORD ROAD</b>                               |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>  |  |   | 23b. DATE<br><b>11/20/84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens Of Faith</b>                              |  | 23d. LOCATION<br><b>Baltimore, Maryland</b> STATE |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J Ruck Inc. Baltimore, Maryland</b>  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 19 1984</b>  |  |   |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Russell</b>  |  |   |  |   |  |  |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Anna Veronica Krebs</i>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>11 14 84</i>   |  | 2b. HOUR<br><i>2:21 P</i>  |
| 3. SEX<br><i>Female</i>   | 4. RACE<br><i>White</i>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>4 21 23</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>61</i> YRS.                              | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Francis Scott Key Medical Center</i> |   | 12a. USUAL OCCUPATION<br>(TYPE OR WORK FOR MOST OF WORKING LIFE)<br><i>Housework</i>                       | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>At Home</i>                            |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>Maryland</i>  |  |   | 13b. COUNTY<br><i>Baltimore</i>  | 13c. CITY OR TOWN<br><i>Baltimore</i>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>John Charles Ketchum</i>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Mary Virginia Flynn</i>                                |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>   |  | 16b. SOCIAL SECURITY NO.<br><i>213-18-0609</i>  |  | 17. INFORMANT<br>ADDRESS<br><i>Gregory Krebs 960 Armisted Walk 21205</i>       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>cardiac arrest</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Pontine infarct</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <i>19</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I (this hospital) attended the deceased from <i>11/1 19 84</i> to <i>11/14 19 84</i> , that (I (we) lost saw the deceased live on <i>11/14 19 84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I (we) (did) not view the body after death.   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Catherine K. Chow</i> MD   |  | DEGREE  |  | 22c. DATE SIGNED<br><i>11/14/84</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>CATHERINE CHOW</i>  |  | 22e. ADDRESS<br><i>FSKMC, 4440 EASTERN AV., BALTO, MD</i>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>   | 23b. DATE<br><i>11-16-84</i>   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Baltimore National</i>   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore City, Md</i>                                    |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Charles S. Zeiler &amp; Son Inc.</i> ADDRESS<br><i>6224 Eastern Ave.</i>   |  |   | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><i>NOV 16 1984</i> <i>Lin Davidson-Randall</i> |  |  |

MEDICAL CERTIFICATION

99

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

• **2008** – **2009**

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251

21

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 4 3 0 0 2 1

|  |  |  |   |  |                                   |
|--|--|--|---|--|-----------------------------------|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH  |   | 2b. HOUR   |                                   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | MONTH DAY YEAR   |   | MONTHS DAYS HOURS MIN.   |                                   |
| JOHN KREINER   |  | NOVEMBER 17, 1984  |   | 06:00PM  |                                   |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | IF UNDER 1 YEAR  |                                   |
| Male   | Cauc.  | MONTH DAY YEAR   | 70 YRS.   | IF UNDER 24 HRS.   |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                   |
| Md.  | U.S.A.   |  | BALTIMORE CITY MD.  |  |                                   |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY |
| BALTIMORE  | THE JOHNS HOPKINS HOSPITAL   |  | Upholsterer   |  | Furniture                         |
| 13a. STATE   |  | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?   | 13e. STREET ADDRESS / ZIP CODE    |
| Md.  |  | Baltimore  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 1600 W. Mt. Royal Ave. 21217   |                                   |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |   | ADDRESS  |                                   |
| FIRST MIDDLE LAST  |  | FIRST MIDDLE LAST  |   | Tauber   |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT  |                                   |
| No   |  | 215-01-5195  |   | Frank Kreiner  |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |   |  |                                   |
| PART I. DEATH WAS CAUSED BY:   |  |  |   |  |                                   |
| IMMEDIATE CAUSE (a)  |  | Respiratory Arrest   |   | 1 minute   |                                   |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |   |  |                                   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  | (b) pulmonary compromise by metastatic CA  |   | 24 days  |                                   |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |   |  |                                   |
| (c) gastric cancer   |  |  |   | 3 yrs  |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |  |   |  |                                   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?  |                                   |
|  |  |  |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                   |
|  |  | HOUR A.M. MONTH DAY YEAR   |   |  |                                   |
|  |  | P.M. 19  |   |  |                                   |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION  |                                   |
| WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |   | STREET CITY OR TOWN COUNTY STATE   |                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/25, 1984, to 11/17, 1984, that (I) (we) last saw the deceased alive on 11/17, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |                                   |
| 22b. SIGNATURE   |  | DEGREE   |   | 22c. DATE SIGNED   |                                   |
| CJ Duffy   |  | MD-PhD   |   | 11/17/84   |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |   |  |                                   |
|  |  | The Johns Hopkins Hospital   |   |  |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |                                   |
| Burial   |  | 11/20/84   |   | Holy Redeemer Cem. Baltimore Md.   |                                   |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE   |                                   |
| NAME ADDRESS   |  | NOV 19 1984  |   | John Davidson Randall  |                                   |
| B. Dabrowski & Son 2818 E. Baltimore St.   |  |  |   |  |                                   |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 4 3 0 0 2 2

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |  |   |  |
|--|--|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Steven KRITZ</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11/12/84</b> |  | 2b. HOUR<br><b>11:55 P.M.</b>                   |  |
| 3. SEX<br><b>M</b>   | 4. RACE<br><b>white</b>                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>07 19 09</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75 25</b> YRS.                                 |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Penna</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. CITY</b> MD.                       |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>FRANCIS SCOTT KEY HOSP.</b>                 |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |   |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>BALTO.</b>  |  | 13c. CITY OR TOWN<br><b>DUNDALK</b>  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ELIZABETH</b>   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>212-10-7590</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>MARY M. KRITZ 1416 STENGAL AVE 22</b>                 |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Massive hemorrhagic stroke</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>3 days</b>  |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)        |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/8</b> , 19 <b>84</b> , to <b>11/12</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>11/12</b> , 19 <b>84</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |   |  |
| 22b. SIGNATURE<br><b>Joseph Adams MD</b>   |  |   |  | 22c. DATE SIGNED<br><b>11/13/84</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Joseph Adams</b>   |  |   |  | 22e. ADDRESS<br><b>Key Medical Center; Baltimore, MD</b>                             |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>11/16/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LORRAINE PARK</b>                           |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>CONNELLY</b>  |  | ADDRESS<br><b>Funeral Home of DUNDALK</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 14 1984</b>                                  |   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>W. J. Connelly</b>  |  |   |  |  |   |  |

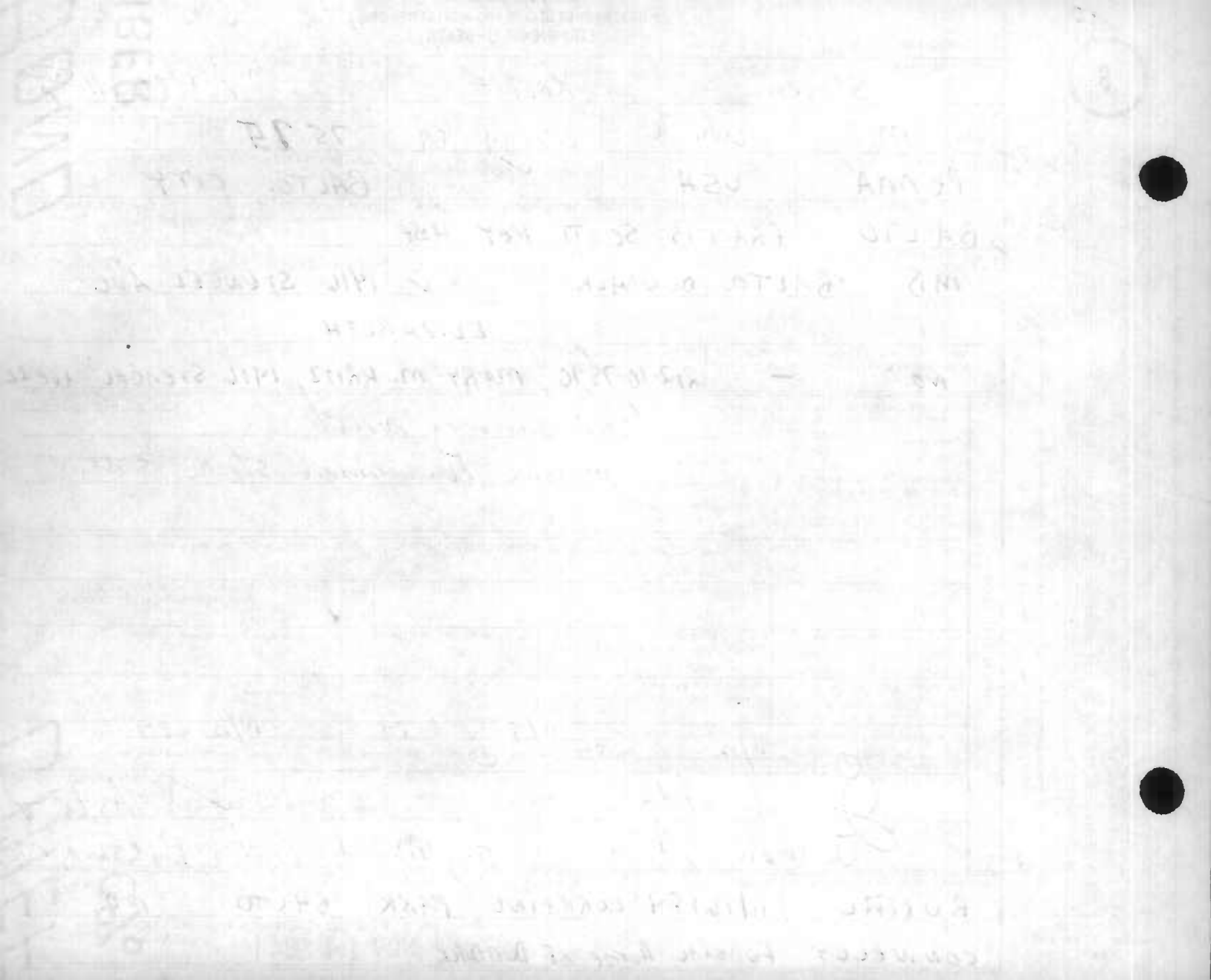
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

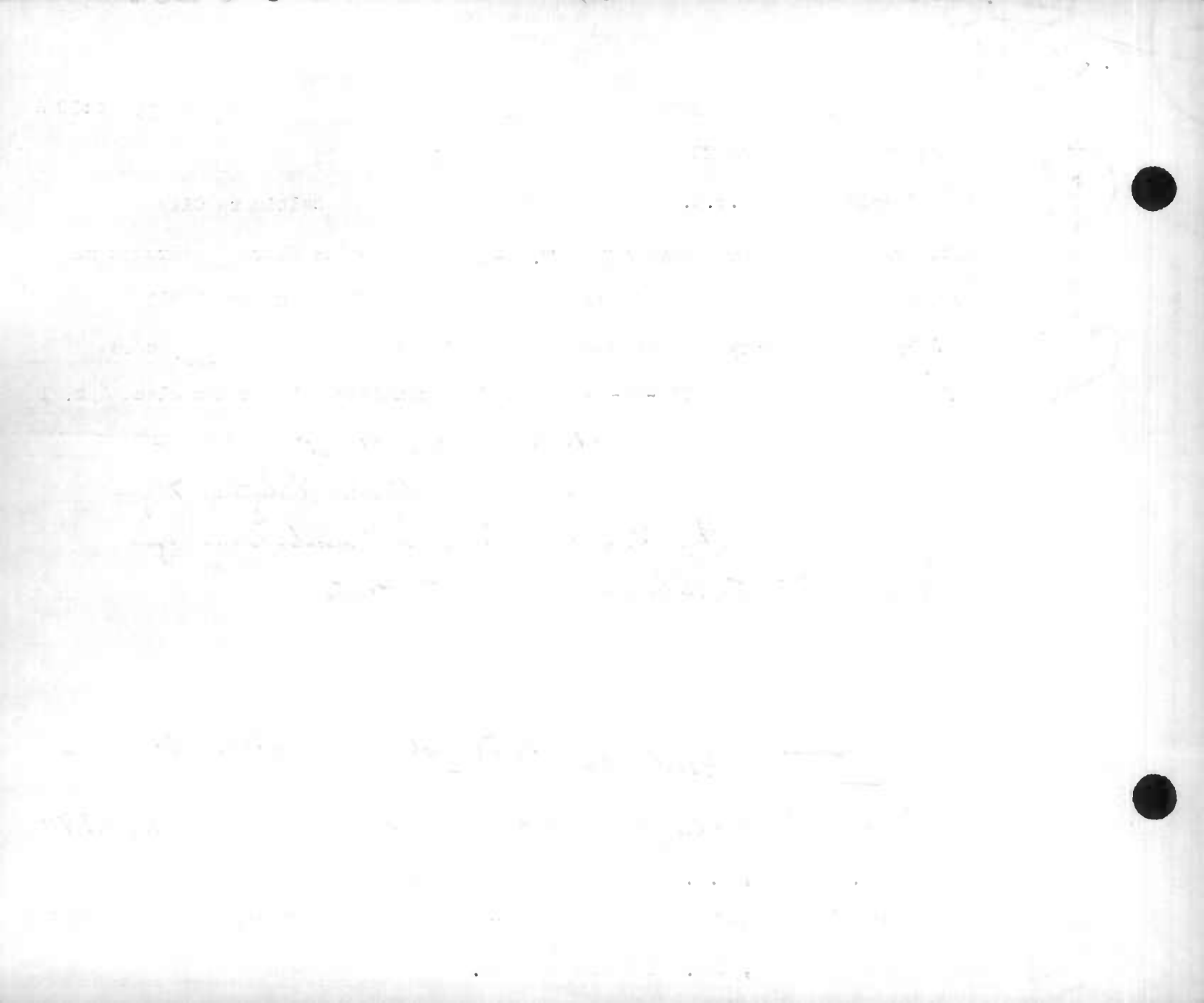
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 3 4 3 0 0 2 3  |  |
|--|--|--|--|--|--|
| 1 - FOR STATE REGISTRAR  |  |  |  | CERTIFICATE OF DEATH   |  |
| 1. DECEASED NAME   |  |  |  | 2a. DATE OF DEATH  |  |
| FIRST MIDDLE LAST  |  |  |  | MONTH DAY YEAR   |  |
| SARAH EDNA KROMM   |  |  |  | 11 19 84   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  |
| FEMALE   |  | WHITE  |  | MONTH DAY YEAR   |  |
|  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |
|  |  |  |  | 82 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>     |  |
| Pennsylvania   |  | U.S.A.   |  | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |
| Baltimore  |  | 4320 CLAREWAY APT. 3-G   |  | Baltimore City MD.   |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| Sales Clerk  |  | Drugstore  |  |  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  |
| Maryland   |  |  |  | Baltimore  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |
| FIRST MIDDLE LAST  |  | FIRST MIDDLE LAST  |  |  |  |
| John Henry Fantom  |  | Emiline McGee  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |
| NO   |  | 214-14-8944  |  | 21228  |  |
|  |  |  |  | Oneida Schneider 413 Wheaton Place Apt. I                                      |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <i>Acute Cardiac Arrest</i>  |  |  |  |  | -  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>Recurrent Ventricular Arrhythmia</i>   |  |  |  |  | 73 years                                     |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>Hypertensive Intracerebral Cardiovascular Disease</i>  |  |  |  |  | years  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Chronic Obstructive Pulmonary Disease; Osteoarthritis</i>  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
|  |  | 19   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |
|  |  |  |  |  |  |
| 22a. I certify that (I) <i>(husband)</i> attended the deceased from <i>11/18/84</i> to <i>11/19/84</i> , that (I) <i>(we)</i> lost saw the deceased alive on <i>9/10/84</i> 19 <i>84</i> , and that in (my) <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above, (I) <i>(we)</i> <i>(did not)</i> view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED   |  |
| <i>Albert B. Bradley</i>   |  | MD   |  | 11/19/84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |  |
| ALBERT B. BRADLEY, M.D.  |  | 4900 BELAIR ROAD   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| Burial   |  | 11/21/84   |  | Loudon Park Cemetery   |  |
|  |  |  |  | Baltimore  |  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |
| NAME ADDRESS   |  | NOV 23 1984  |  | <i>Lidia Davidson-Randall</i>  |  |
| HUBBARD FUNERAL HOME, INC.   |  | 4107 WILKENS AVE.  |  |  |  |

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

30024  
REG. NO.

1- FOR STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  
FREDERICK Albert KUHN, Jr.

2a. DATE KNOWN OF DEATH ☒ MONTH DAY YEAR  
ESTIMATED ☐ 11 10 19 84

2b. HOUR ☐ M

3 SEX Male 4. RACE White 5. DATE OF BIRTH MONTH DAY YEAR 1 4 1950 6. AGE (IN YEARS) (LAST BIRTHDAY) 34 YRS. 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.

10. CITY OR TOWN OF DEATH Baltimore 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Med. Center (DOA) 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Operator-Continental Can 12b. KIND OF BUSINESS OR INDUSTRY

13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Dundalk 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ 13e. STREET ADDRESS 21222 2126 Willow Spring Road

14. FATHER'S NAME FIRST MIDDLE LAST Frederick A. Kuhn, Sr. 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary F. Pullen

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes 16b. SOCIAL SECURITY NO. Vietnam 219-50-6895 17. INFORMANT 3807 Old North Point Road-B Balto., MD. 21222

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1 DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease  
DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:  
(b) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF  
(c) \_\_\_\_\_

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK ☐ AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE [Signature] TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER DATE SIGNED 11-11-84

EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. ADDRESS 111 Penn St., Balto., Md. 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 11/14/84 23c. NAME OF CEMETERY OR CREMATORY Baltimore National 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland

24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. ADDRESS 7922 Wise Avenue Dundalk, MD. 21222 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

NOV 14 1984

20% COTTON FIBER

DAVID S. H. H. H.



## CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |  |   |   |                                |   |  |  |
|--|--|--|---|---|--------------------------------|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>JACOB KUPERMAN  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>11 14 84                |   | 2b. HOUR<br>2:56 AM            |   |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>9 26 1901  |                                | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN<br>82 83   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Poland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Levindale |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><del>Salesman</del> CHAUFFEUR   |                                | 12b. KIND OF BUSINESS OR INDUSTRY<br>CABS   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE<br>Md   |  |  | 13b. COUNTY<br>Baltimore                                    |   | 13c. CITY OR TOWN<br>Baltimore |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>SHLOMER KUPERMAN  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>MATLA UNKNOWN |   |                                |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>216-10-7827  |   | 17. INFORMANT MR. LEE KUPERMAN<br>704 SUDBROOK RD. BALTO., MD 21208   |                                |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) ACUTE M.I.<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |   |   |                                |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |   |                                |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                                |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |                                |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-18-84 to 11-14-84, that (I) (we) lost saw the deceased alive on 11-18-84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                  |  |  |   |   |                                |   |  |  |
| 22b. SIGNATURE<br>[Signature]  |  | DEGREE<br>M.D.   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |                                | 22c. DATE SIGNED<br>11-14-84  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SEJ H T W A R   |  | 22e. ADDRESS<br>Levindale Hebrew Geriatric Ctr<br>& Hosp - 2434 W. Belvedere Ave Md 21215                              |   |   |                                |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>NOV. 16, 1984   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>SHOMREI HADATH VE TZEMECH SEDEK   |                                | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>ROSEDALE BALTO., MD  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD. BALTO., MD 21215  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 20 1984  |                                | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examination must be fulfilled at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 4 3 0 0 2 6  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |  |   |   |   |   |
|---|--|---|---|--|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   | 2a. DATE OF DEATH   |  |   | 2b. HOUR  |   |   |
| FIRST MARY MIDDLE L. LAST KWIATOWSKI  |  |   | MONTH NOVEMBER DAY 10 YEAR 1984                             |  |   | 8:00 P.M.   |   |   |
| 3. SEX<br>FEMALE  | 4. RACE<br>WHITE   | 5. DATE OF BIRTH<br>MONTH 6 DAY 3 YEAR 1900   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS.                  |  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>NEW YORK   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |  |   |   |   |   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>CHURCH HOSPITAL |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOMEMAKER      |   |   | 12b. KIND OF BUSINESS OR INDUSTRY   |   |
| 13a. STATE<br>MARYLAND  |  | 13b. COUNTY   | 13c. CITY OR TOWN<br>BALTIMORE                              |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |   | 13e. STREET ADDRESS / ZIP CODE<br>3127 ELLIOTT ST 21216 |
| 14. FATHER'S NAME<br>FIRST GEORGE MIDDLE LATKA LAST   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST VALERIA MIDDLE OSIKA LAST |  |   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |   | 17. INFORMANT<br>ADDRESS<br>DANIEL KWIATKOWSKI 731 S. CURLEY ST                    |   |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) CEREBRAL VASCULAR ACCIDENT<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |   |   |  |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH         |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |   |   |  |   |   |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)      |   |   |   |   |
| 21d. INJURY OCCURRED<br>IN HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                  |   |   |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from NOVEMBER 03, 1984, to NOVEMBER 10, 1984, that (I/we) last saw the deceased alive on NOVEMBER 10, 1984, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.) |  |   |   |  |   |   |   |   |
| 22b. SIGNATURE<br>GARY A. WAND M.D.   |  |   |   | DEGREE<br>M.D.   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br>11-10-84                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |   | 22e. ADDRESS<br>CHURCH HOSPITAL CORPORATION<br>100 NORTH BROADWAY BALTO. MD. 21231 |   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL   |  | 23b. DATE<br>11/14/1984   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>SACRED HEART MARY                            |   | 23d. LOCATION<br>CITY OR TOWN COUNTY<br>BALTIMORE C MD.   |   |   |
| 24. FUNERAL DIRECTOR<br>RAYMOND L. KACZO ROWSKI 2525 FLEET ST.  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 13 1984                                       |   | 25b. REGISTRAR'S SIGNATURE<br>Davidson-Rendall  |   |   |

BP

1. *Chrysomelidae*  
 2. *Curculionidae*  
 3. *Chrysomelidae*  
 4. *Chrysomelidae*  
 5. *Chrysomelidae*  
 6. *Chrysomelidae*  
 7. *Chrysomelidae*  
 8. *Chrysomelidae*  
 9. *Chrysomelidae*  
 10. *Chrysomelidae*

11. *Chrysomelidae*  
 12. *Chrysomelidae*  
 13. *Chrysomelidae*  
 14. *Chrysomelidae*  
 15. *Chrysomelidae*  
 16. *Chrysomelidae*  
 17. *Chrysomelidae*  
 18. *Chrysomelidae*  
 19. *Chrysomelidae*  
 20. *Chrysomelidae*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

Russell LaBue

REG. NO.

|   |  |                              |  |   |                                   |  |  |   |  |   |  |
|---|--|------------------------------|--|---|-----------------------------------|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>Russell</u> <u>MMI</u> <u>LaBue</u>  |  |                              | 2a. DATE OF DEATH MONTH <u>11</u> DAY <u>10</u> YEAR <u>84</u>   |   |                                   | 2b. HOUR <u>1:50A.M.</u>   |  |   |  |   |  |
| 3. SEX <u>Male</u>  |  | 4. RACE <u>W</u> <u>Hite</u> |  | 5. DATE OF BIRTH MONTH <u>02</u> DAY <u>07</u> YEAR <u>07</u> |                                   | 6. AGE (IN YEARS LAST BIRTHDAY) <u>77</u> YRS.   |  | IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u> |  | IF UNDER 24 HRS. HOURS <u></u> MIN. <u></u> |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Italy</u>                       |  |                              | 7b. CITIZEN OF WHAT COUNTRY? <u>Italy</u>  |   |                                   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>City</u> <u>Baltimore City</u> MD. |   |  |
| 10. CITY OR TOWN OF DEATH <u>Baltimore</u>                                  |  |                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Univ of Maryland Hosp.</u> |   |                                   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Self employed</u>   |  |   | 12b. KIND OF BUSINESS OR INDUSTRY <u>Dry Cleaning</u>                      |   |  |
| 13a. STATE <u>Maryland</u>  |  |                              | 13b. COUNTY <u>Baltimore</u>   |   | 13c. CITY OR TOWN <u>Eastport</u> |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE <u>8015 Lansdale Road 21224</u>             |   |  |
| 14. FATHER'S NAME FIRST <u>Patsy</u> MIDDLE <u></u> LAST <u>LaBue</u>       |  |                              | 15. MOTHER'S MAIDEN NAME FIRST <u>Cora</u> MIDDLE <u></u> LAST <u>unknown</u>  |   |                                   |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u> |  |                              | 16b. SOCIAL SECURITY NO. <u>203-07-1084</u>  |   |                                   | 17. INFORMANT ADDRESS <u>Margaret LaBue same as 13e</u>  |  |   |  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiopulmonary Arrest

DUE TO, OR AS A CONSEQUENCE OF

(b) Heart Failure

DUE TO, OR AS A CONSEQUENCE OF

(c) presumed sepsis

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

status post Coronary Artery Bypass Grafts

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 19a. DATE OF OPERATION <u>9/26/84</u>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Unstable Angina</u> |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>19</u>                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)     |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/25</u> , 19 <u>84</u> to <u>11/10</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>11/10</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |
| 22b. SIGNATURE <u>Paul R. Ringelman</u>  |  | DEGREE <u>MD</u>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED <u>11/10/84</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Paul R. Ringelman</u>   |  | 22e. ADDRESS <u>Univ of Md Hosp, Baltimore</u>                          |  |   |  |   |  |

|   |  |                             |  |   |  |   |  |
|---|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>                    |  | 23b. DATE <u>11/12/1984</u> |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Green Mount Crematory</u> |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore City, Maryland</u> |  |
| 24. FUNERAL DIRECTOR NAME <u>Walter Brooks Bradley, Inc. Balto., MD 21222</u> |  |                             |  | 25a. DATE REC'D. BY REGISTRAR <u>NOV 13 1984</u>                |  | 25b. REGISTRAR'S SIGNATURE <u>Phila Davidson-Rendall</u>                |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 4 3 0 0 2 8  
CERTIFICATE OF DEATH

FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |  |   |   |                                   |  |                             |  |
|--|--|---|---|---|--|---|---|-----------------------------------|--|-----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Virgie F LAHNER</i> |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>NOV 5 - 1984</i> |   | 2b. HOUR<br><i>1:35 AM</i>                                       |   |   |                                   |  |                             |  |
| 3. SEX<br><i>FEMALE</i>  |  | 4. RACE<br><i>CAUCASIAN</i>   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>4 24 00</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>84</i> YRS.                                     |   | IF UNDER 1 YEAR MONTHS DAYS       |  | IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Md.</i>                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City MD.</i>                     |   |                                   |  |                             |  |
| 10. CITY OR TOWN OF DEATH<br><i>Balto.</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Good Samaritan Hospital</i> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Home Maker</i> |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |                             |  |
| 13a. STATE<br><i>Md.</i>   |  |   | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><i>Balto.</i>                               |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   | 13e. STREET ADDRESS / ZIP CODE<br><i>5919 Kavan Avenue-21206</i> |                             |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>Pleasant I. Fowble</i>                   |  |   |   |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Mattie Mae Martin</i>                |   |                                   |  |                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>  |  |   | 16b. SOCIAL SECURITY NO.<br><i>215-09-6811</i>          |   | 17. INFORMANT ADDRESS<br><i>5919 Kavan Ave. Balto. Md. 21206</i> |   |   |                                   |  |                             |  |

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

## PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *Cardiac arrest*

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) *severe congestive cardiomyopathy*

DUE TO, OR AS A CONSEQUENCE OF

(c) *coronary artery disease*

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

*1 year*

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

MEDICAL CERTIFICATION

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <i>NOV. 4th</i> , 19 <i>84</i> , to <i>NOV. 5th</i> , 19 <i>84</i> , that (1) (we) lost saw the deceased alive on <i>NOV 5th</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) not view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><i>E. J. Woods</i>  |  | DEGREE<br><i>M.D.</i>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><i>11/05/84</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>E. J. WOODS</i>   |  | 22e. ADDRESS<br><i>600 N. Wolfe St<br/>Baltimore, MD. 21205</i>        |  |  |  |  |  |

|  |  |                             |  |  |  |   |  |
|--|--|-----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i> |  | 23b. DATE<br><i>11-8-84</i> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Balto. Natl. Cem.</i> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Balto. Md.</i> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>John C. Miller Inc-</i> |  |                             |  | ADDRESS<br><i>6415 Belair Rd.</i>                              |  | 25a. DATE REC'D. BY REGISTRAR<br><i>NOV 8 1984</i>              |  |
|  |  |                             |  | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson</i>            |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR  
GERARD A. LAMBERT

|   |   |  |   |  |                      |
|---|---|--|---|--|----------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>GERARD ANDREW LAMBERT  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 30 84   |  | 2b. HOUR<br>1205 A M |
| 1 SEX<br>Male   | 4 RACE<br>white   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 1 16   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS.   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS.<br>HOURS MIN. |                      |
| 8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 8b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>           | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>City MD.  |  |                      |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Finance   | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S. Gov't.                               |                      |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland  |   |  | 13b. CITY OR TOWN<br>Catonsville  | 13c. STREET ADDRESS / ZIP CODE<br>506 Academy Rd. 21228                        |                      |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Thomas J. Lambert   |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elizabeth Ellinghaus   |  |                      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW II 212-10-6366  | 17. INFORMANT ADDRESS<br>Louise B. Lambert - Same as Sec. 13   |   |  |                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CHRONIC OBSTRUCTIVE LUNG DISEASE<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) PULMONARY RADIATION THERAPY<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) CARCINOMA OF THE LUNG<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>YRS |   |  |   |  |                      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).<br>GENERALIZED ATHEROSCLEROSIS  |   |  |   |  |                      |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |  |                      |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |                      |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                 |   |  |   |  |                      |
| 22b. SIGNATURE<br>James E Taylor  |   | DEGREE<br>M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br>11/30/84   |                      |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JAMES E. TAYLOR, M.D.  |   | 22e. ADDRESS<br>Baltimore, Md.<br>ST. AGNES HOSPITAL   |   |  |                      |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  | 23b. DATE<br>12/3/84  | 23c. NAME OF CEMETERY OR CREMATORY<br>Crestlawn Cemetery   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Marriottsville Md.  |  |                      |
| 24. FUNERAL DIRECTOR<br>Leroy M. & Russell C. Witzke<br>1630 Edmondson Avenue, Catonsville, Md. 21228   |   |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 4 1984   | 25b. REGISTRAR'S SIGNATURE<br>Davidson-Randall                                 |                      |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the county health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.



|                         |  |                           |  |
|-------------------------|--|---------------------------|--|
| 1. NAME OF SUBJECT      |  | 2. ALIAS                  |  |
| 3. DATE OF BIRTH        |  | 4. PLACE OF BIRTH         |  |
| 5. SEX                  |  | 6. RACE                   |  |
| 7. HEIGHT               |  | 8. WEIGHT                 |  |
| 9. HAIR COLOR           |  | 10. EYE COLOR             |  |
| 11. BUILD               |  | 12. MARKS                 |  |
| 13. EDUCATION           |  | 14. OCCUPATION            |  |
| 15. RELIGION            |  | 16. POLITICAL AFFILIATION |  |
| 17. SOCIAL BACKGROUND   |  | 18. CRIMINAL RECORD       |  |
| 19. CURRENT ADDRESS     |  | 20. PREVIOUS ADDRESSES    |  |
| 21. CONTACT INFORMATION |  | 22. COMMENTS              |  |

NOV 1964

NOV 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove earlier papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |   |   |  |   |  |
|--|--|---|--|---|---|---|--|---|--|
| 1- FOR STATE REGISTRAR   |  | RICHARD M. LANDWEHR   |  |   |   | REG. NO.  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>RICHARD M LANDWEHR  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 27 84 |   |  | 2b. HOUR<br>0400 A.M.   |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>Caucasian  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 20 12  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 9b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SOUTH BALTIMORE GEN. Hospital                |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Sheet Metal Worker          |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Md. Drydock  |  |
| 13a. USUAL RESIDENCE (NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Howard   |  | 13c. CITY OR TOWN<br>Ellicott City  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>10188 Rt# 99 21043  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Max Landwehr   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Hermine Schmidt  |  |   |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>unknown  |  | 17. INFORMANT<br>ADDRESS<br>Hannah Landwehr Same as # 13  |   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Respiratory Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Asbestosis lung dz.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |   |  |   |   |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/24</u> , 19 <u>84</u> , to <u>11/27</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>11/27</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                  |  |   |  |   |   |   |  |   |  |
| 22b. SIGNATURE<br><u>W. Rahming</u>  |  | DEGREE<br>M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   |   | 22c. DATE SIGNED<br>11/27/84  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>W. RAHMING  |  | 22e. ADDRESS<br>3001 S. HANOVER ST. 21230   |  |   |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>11/30/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Woodlawn Cemetery   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Woodlawn Md.                                      |  |   |  |
| 24. FUNERAL DIRECTOR<br>Leroy M. & Russell C. Witzke Funeral Homes P.A.<br>1630 Edmondson Avenue, Catonsville, Md. 21228   |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 30 1984  |  | 25b. REGISTRAR'S SIGNATURE<br><u>a. Davidson</u>  |  |



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100%



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M
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 (VR A15 ME (5))

 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |  |                     |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |  |  |
|---|--|---------------------|--|--|--|--|--|--|--|--|--|---|--|---|--|--|--|--|--|
| 1- FOR STATE REGISTRAR  |  |                     |  |  |  |  |  |  |  | 30031  |  |   |  |   |  |  |  |  |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>CLARENCE C. LANE</b>  |  |                     |  |  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>11</b> DAY <b>15</b> YEAR <b>84</b> |  |   |  |   |  |  |  |  |  |
| 3 SEX <b>MALE</b>   |  | 4 RACE <b>WHITE</b> |  | 5 DATE OF BIRTH<br>MONTH <b>8</b> DAY <b>24</b> YEAR <b>20</b>   |  | 6 AGE (IN YEARS)<br>LAST BIRTHDAY <b>64</b> YRS.                                     |  | IF UNDER 1 YR.<br>MONTHS <b>0</b> DAYS <b>0</b>  |  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b>   |  | 7c. DATE PRONOUNCED DEAD <b>11-15-84</b>  |  | 2d. HOUR <b>11:05A</b>                                |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |  |                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                   |  |   |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |                     |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>IN SUCH FACILITY, GIVE STREET ADDRESS<br><b>521 Lucia Avenue</b> |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Tractor Trailer Driver</b>           |  |   |  | 12b. KIND OF BUSINESS<br><b>K.A.T. Auto Transport</b> |  |  |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  |                     |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>521 Lucia Avenue</b>   |  |   |  | 21229   |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Malcum</b> MIDDLE <b>Lane</b> LAST <b>Lane</b>  |  |                     |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Ethel</b> MIDDLE <b>Kirby</b> LAST <b>Kirby</b> |  |  |  |  |  |   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>YES</b>   |  |                     |  | (IF YES, GIVE WAR OR DATES)<br><b>WW II</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>224-09-1870</b>                                       |  | 17. INFORMANT<br><b>Delores M. Lane</b>  |  |  |  | ADDRESS<br><b>521 Lucia Avenue 21229</b>  |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                 |  |                     |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |                     |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |  |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |   |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                     |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |  |  | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |  |  |   |  |   |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                     |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE<br><i>Margarita A. Korell</i>  |  |                     |  | TITLE (SPECIFY)<br><b>Assistant</b>  |  |  |  | M.D. <b>Assistant</b> MEDICAL EXAMINER   |  |  |  | DATE SIGNED <b>11-15-84</b>   |  |   |  |  |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>   |  |                     |  | ADDRESS<br><b>111 Penn Street</b>  |  |  |  |  |  |  |  |   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |  |                     |  | 23b. DATE<br><b>11/19/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Crestlawn Mem. Park</b>                     |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY <b>Marriottsville Howard Md.</b>                                    |  |   |  |   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Hubbard Funeral Home, Inc.</b> ADDRESS <b>4107 Wilkens Ave.</b>   |  |                     |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 16 1984</b>                                  |  | 25b. REGISTRAR'S SIGNATURE<br><i>John Davidson</i>   |  |  |  |   |  |   |  |  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

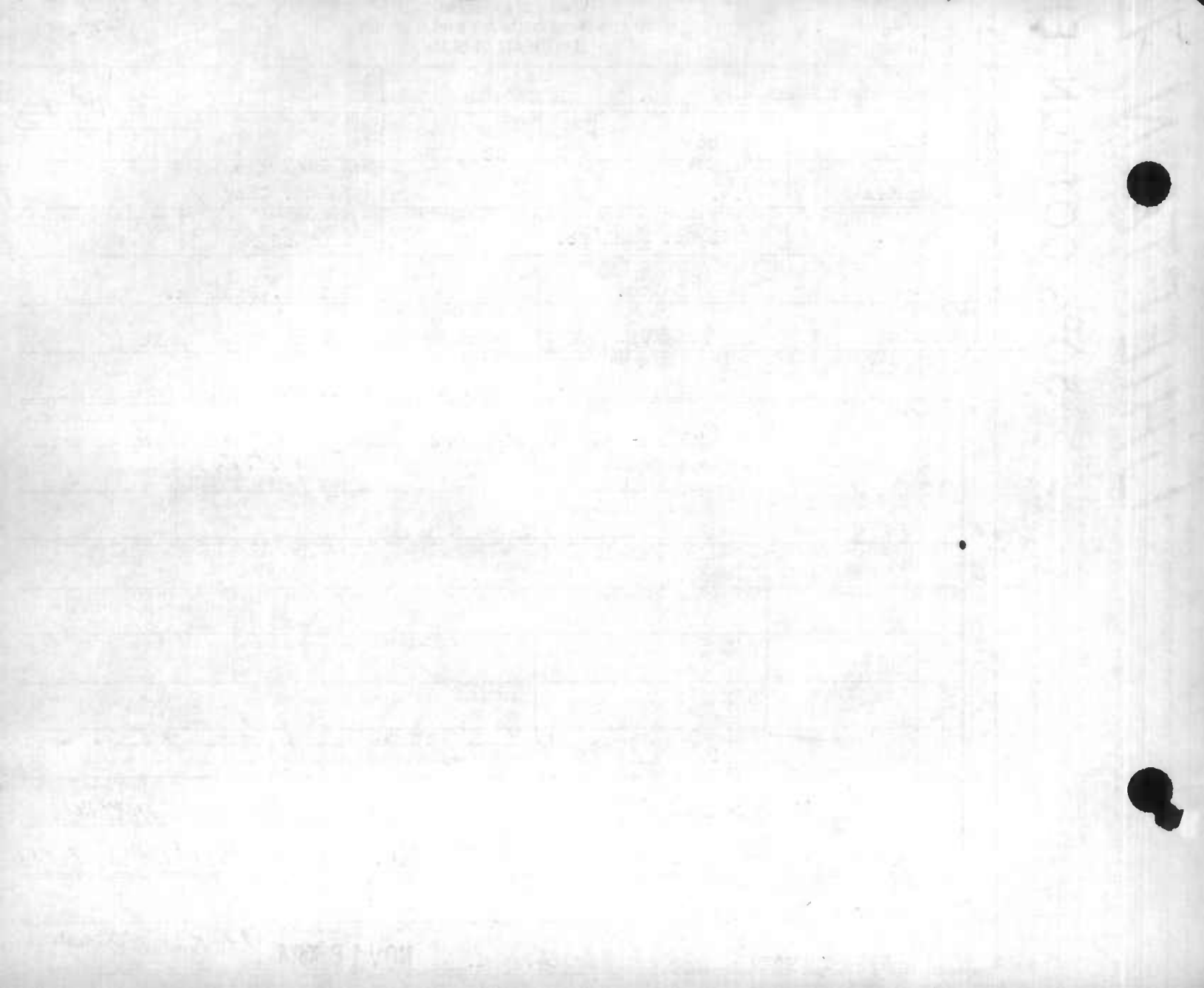
DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |  |  |
|--|--|---|--|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>HOWARD D. LANGFORD</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 4 84</b>                  |   |  | 2b. HOUR<br><b>11 30 P.M.</b>  |  |  |
| 3 SEX<br><b>Male</b>   |  | 4 RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 23 96</b>  |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>87</b> YRS.                                  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Canada</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.                       |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3501 St. Paul St.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>PROFESSOR</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>Md.</b>   |  |   | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Balto.</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET ADDRESS<br><b>3501 St. Paul St.</b>  |  |   | 13f. ZIP CODE<br><b>21218</b>  |   |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles Langford</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Jennie White</b>  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |   | 16b. SOCIAL SECURITY NO.<br><b>577-30-6499</b>                         |   | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Beatrice W. Langford - Same as #13</b> |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Coronary artery disease presumed Myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a   |  |   |  |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>10/24/84</b> to <b>11/4/84</b> , that (I) (we) lost saw the deceased alive on <b>10/24/84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |  |
| 22b. SIGNATURE<br><b>John W. Bowie MD</b>  |  |   |  |   |  | 22c. DATE SIGNED<br><b>11/8/84</b>   |  | 22d. ADDRESS<br><b>500 W. Uniopkwy Balt. Md 21210</b>  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Removal</b>   |  |   | 23b. DATE<br><b>11/4/84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Anatomy Board</b>   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 16 1984</b>                                  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Davidson-Randall</b>  |

BP





STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

 1- FOR  
 STATE  
 REGISTRAR

|  |  |   |   |   |  |
|--|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Arthur Orval Lankford, Jr.</b>          |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>November 23, 1984</b>                                    |   | 2b. HOUR<br><b>10:30 P.M.</b>                                    |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>9 28 1921</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Washington D.C.</b>            | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Francis Scott Key Center</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Tool &amp; Dye Maker</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Beth. Steel</b>          |
| 13a. STATE<br><b>Maryland</b>  |  |   | 13b. CITY OR TOWN<br><b>Baltimore</b>   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13d. STREET ADDRESS / ZIP CODE<br><b>818 Wise Avenue 21222</b>   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Arthur O. Lankford, SR</b>        |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elsie May Allen</b>                         |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b> |  | 16b. SOCIAL SECURITY NO.<br><b>215-14-8490</b>  |   | 17. INFORMANT<br><b>Rose Mary Lankford</b> Same as 13e  |  |

|  |  |  |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest due to ventricular fibrillation -</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Coronary artery disease -</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)

|   |  |   |  |
|---|--|---|--|
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/17/84</b> to <b>Nov 23 1984</b> , that (I) (we) lost saw the deceased above, (I) (we) (did) (did not) view the body after death 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated |  |   |  |
| 22b. SIGNATURE<br><b>Rafael Perez-Mera M.D.</b>   |  | 22c. DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22d. DATE SIGNED<br><b>11-24-84</b>  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Rafael Perez-Mera M.D.</b>  |  | 22f. ADDRESS<br><b>5400 Old Court Rd. Randallstown Md.</b>  |  |

|  |                              |   |   |
|--|------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Entombment</b>                                  | 23b. DATE<br><b>11/27/84</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park</b>    | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b> |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, MD. 21222</b> |                              | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 28 1984</b>         |   |
|  |                              | 25b. REGISTRAR'S SIGNATURE<br><b>Lelia Davidson-Randall</b> |   |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report filed.

1

Contract for  
the purchase of  
the land in the  
vicinity of the  
city of New York

18

18-54-24

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO. 84 30034   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR 11 12 84   |  |   |  |
| 1 DECEASED NAME FIRST MIDDLE LAST ELIZABETH LAPARDE  |  |   |  | 2b. HOUR 0650   |  |   |  |
| 3 SEX Female   |  | 4 RACE Black  |  | 5. DATE OF BIRTH MONTH DAY YEAR 8 16 1925   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 59  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore  |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Provident Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE Md.   |  |   |  | 13b. COUNTY Baltimore   |  | 13c. CITY OR TOWN Baltimore   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Brines LaParde   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Parris   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |  |   |  | 16b. SOCIAL SECURITY NO. 095-22-7574  |  | 17. INFORMANT ADDRESS Elenora Hood 1036 W. Olney Ave. Phila, Pa.  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>SEVERE BLEEDING DIATHESIS</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>ALCOHOLIC LIVER DISEASE</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>40 min.</u><br><u>12 hrs.</u><br><u>5 years</u> |  |   |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>RENAL FAILURE</u>   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (this hospital) attended the deceased from <u>11/10</u> , 19 <u>84</u> , to <u>11/12</u> , 19 <u>84</u> , that (we) lost (saw the deceased alive on <u>11/12</u> , 19 <u>84</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death.  |  |   |  |   |  |   |  |
| 22b. SIGNATURE <u>Stephen M. Seabron</u> DEGREE <u>MD.</u>   |  |   |  | 22c. DATE SIGNED <u>11/12/84</u>  |  | 22d. ADDRESS <u>2600 Liberty Sts Ave.</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>  |  | 23b. DATE <u>11-16-84</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>   |  | 23d. LOCATION <u>Bm/40</u> COUNTY <u>MD.</u>  |  |
| 24. FUNERAL DIRECTOR <u>William C. Brown</u>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR <u>NOV 19 1984</u> 25b. REGISTRAR'S SIGNATURE <u>Phila Davidson-Randall</u>   |  |   |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

30035

FOR  
STATE  
REGISTRAR

|  |                         |  |  |  |   |   |   |  |  |
|--|-------------------------|--|--|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Laura M. Larson</b>  |                         |  | 2a. DATE KNOWN OF DEATH<br>xx MONTH DAY YEAR<br><b>11 7 19 84</b>          |  |   | 2b. HOUR<br>M<br><b>6:50P</b>   |   |  |  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 17, 1965</b>   | 6. AGE (IN YEARS)<br>LAST MONTH DAY YRS<br><b>18</b>                       | IF UNDER 24 YR.<br>MONTHS DAYS HOURS MIN.  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>11 7 19 84</b>   | 7d. HOUR<br>M<br><b>6:50P</b>   |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital</b> |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING TIME)<br><b>Part-time Deli. Dept. Super</b>               |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Thrift</b>                                  |  |  |
| 13a. STATE<br><b>Maryland</b>  |                         | 13b. COUNTY<br><b>Anne Arundel</b>   |  | 13c. CITY OR TOWN<br><b>Pasadena</b>   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS<br><b>8402 Isles Drive Pasadena, Md. 21122</b> |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Paul L. Larson, Jr.</b>   |                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary J. La Page</b>    |  |   | 16. ADDRESS<br><b>Pasadena, Md. 21122</b>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>NO</b>   |                         | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>213-98-1728</b>  |  | 17. INFORMANT<br><b>Mr. Paul L. Larson, Jr. 8402 Isles Drive</b>   |   |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple injuries</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |                         |  |  |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |                         |  |  |  |   |   |   |  |  |
| 19a. DATE OF OPERATION   |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                          |  |   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         |  | 21b. TIME OF INJURY<br>HOUR MONTH DAY YEAR<br><b>4:30 P.M. 11 7 19 84</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Driver in auto/bus impact</b> |   |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>road</b> |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY<br><b>Mountain Rd. nr. Flannigan Farm Rd, Pasadena, A.ACO, MD.</b>    |   |   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                         |  |  |  |   |   |   |  |  |
| ACTUAL SIGNATURE<br><b>Thomas D. Smith</b>   |                         |  | TITLE (SPECIFY)<br>M.D. <b>Deputy Chief</b>                                |  |   |   | DATE SIGNED<br><b>11/8/84</b>   |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Thomas D. Smith, M.D.</b>   |                         |  | ADDRESS<br><b>111 Penn St. Balto., Md.</b>                                 |  |   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |                         |  | 23b. DATE<br><b>11/10/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Memorial Park</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie Anne Arundel Md.</b>   |  |  |
| 24. FUNERAL DIRECTOR<br><b>Mc Guffy Funeral Home of Pasadena</b>   |                         |  | ADDRESS<br><b>Mountain &amp; Tick Neck Rds. Pasadena, Md. 21122</b>        |  | 25a. DATE REC'D. BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>                          |  |  |

NOV 14 1984



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |   |  |  |  |
|---|--|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>James Lassiter</b>   |  |   | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>17</b> YEAR <b>1984</b> |   |  | 2b. HOUR<br><b>12:15 am</b>  |  |
| 3. SEX<br><b>male</b>   |  | 4. RACE<br><b>BLACK</b>   |   | 5. DATE OF BIRTH<br>MONTH <b>August</b> DAY <b>25</b> YEAR <b>1915</b>  |  | 6. AGE (IN YEARS, LAST BIRTHDAY)<br><b>69</b>  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>unknown</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. City</b> MD.   |  |
| 11. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Greater Pennsylvania Ave Nsg Center</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MARYland</b>   |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><b>BALTO</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST <b>unknown</b> MIDDLE <b>unknown</b> LAST <b>unknown</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>unknown</b> MIDDLE <b>unknown</b> LAST <b>unknown</b>  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.<br><b>705-12-6529</b>   |  |
| 16c. YES, NO OR UNKNOWN   |  | 16d. IF YES, GIVE WAR OR DATES  |   | 17. INFORMANT<br><b>Nathie Fludd</b>  |  | 17. ADDRESS<br><b>1203 Argy 1/2 Ave BALTO MD 21217</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO-PULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>SEVERE COPD and Congestive Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CARDIAC ARRHYTHMIAS</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)  |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>[Signature]</b>  |  |   |   | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>11/17/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A. OSEI-WUSU MD</b>   |  |   |   | 22e. ADDRESS<br><b>5710 WABASH AVE. BALTO. MD 21215</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11/26/84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Zion Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Landsdown, Md.</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H, Inc.</b>   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 28 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |
| ADDRESS<br><b>1101 E. North Ave.</b>  |  |   |   |   |  |  |  |

BP





WHILE IN

20% COTTON FIBER

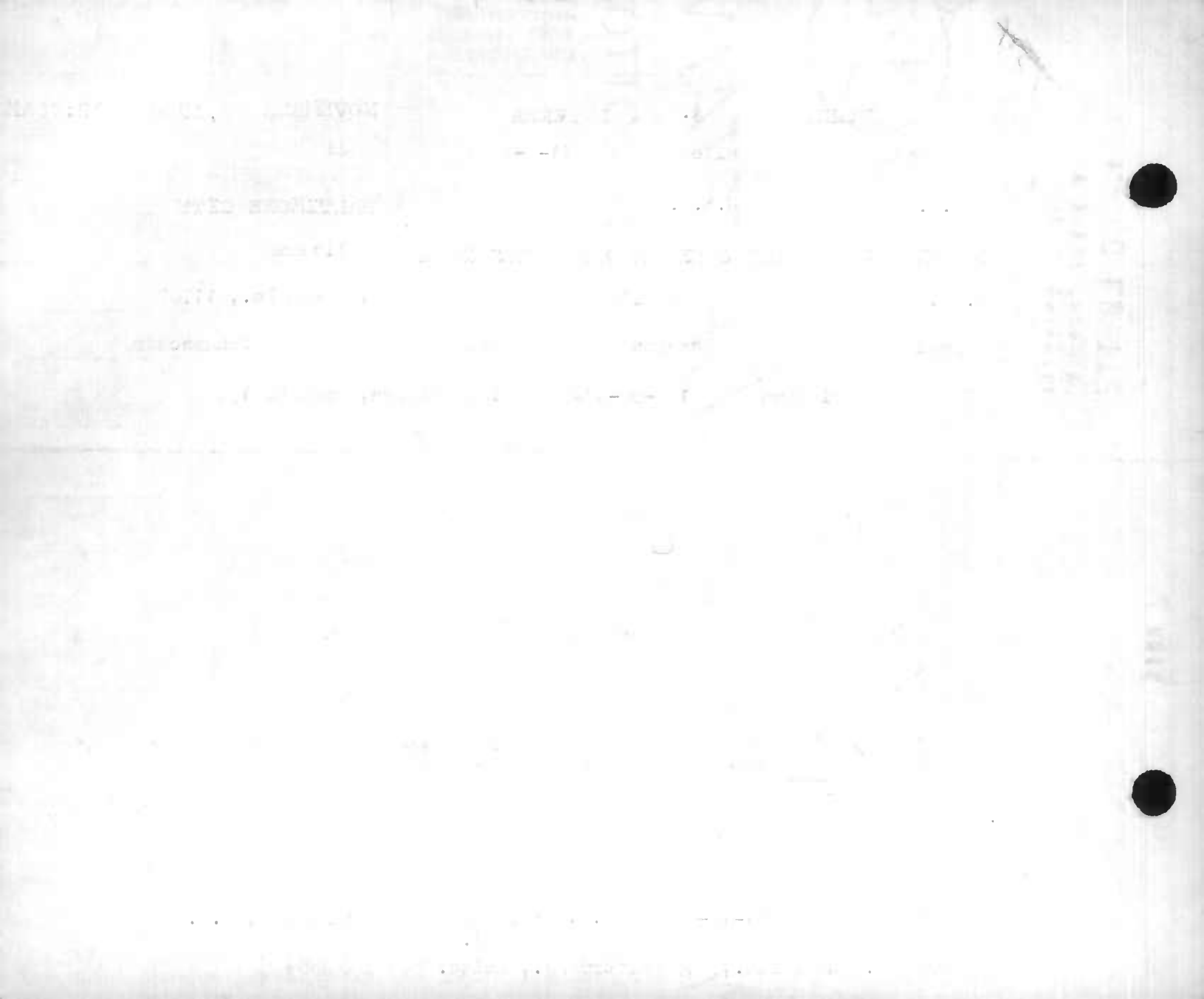


STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - STATE  
REGISTRAR

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>FRANK A. LATERZA</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>NOVEMBER 09, 1984</b>                         |  | 2b. HOUR<br><b>02:45AM</b>   |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>11-6-1940</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>44</b> YRS.                                    | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS.                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.Y.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Policeman</b> | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>N. Y.</b>   |  |   | 13b. COUNTY<br><b>Sayville</b>   | 13c. CITY OR TOWN<br><b>Sayville</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Paul Laterza</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rose Schumacher</b>              |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>126-30-3748</b>  |  | 17. INFORMANT ADDRESS<br><b>Marion Laterza, Same as 13c</b>                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Cardiac failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Marfan's syndrome</b>  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>9/30/84</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Aortic insufficiency &amp; Aortic aneurysm</b>   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NO: WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Sept 14</b> , 19 <b>84</b> , to <b>Nov. 9</b> , 19 <b>84</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Nov. 9</b> , 19 <b>84</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Vincent K.H. Tam</b>  |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>11/9/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Vincent K.H. Tam</b>   |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>11-13-84</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>V.A. National</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Calverton, N.Y.</b>                 |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck, Inc., 5305 Harford Rd., Balto.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 13 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Davidson-Randall</b>                             |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 3 0 0 3 8

1 - FOR  
STATE  
REGISTRAR

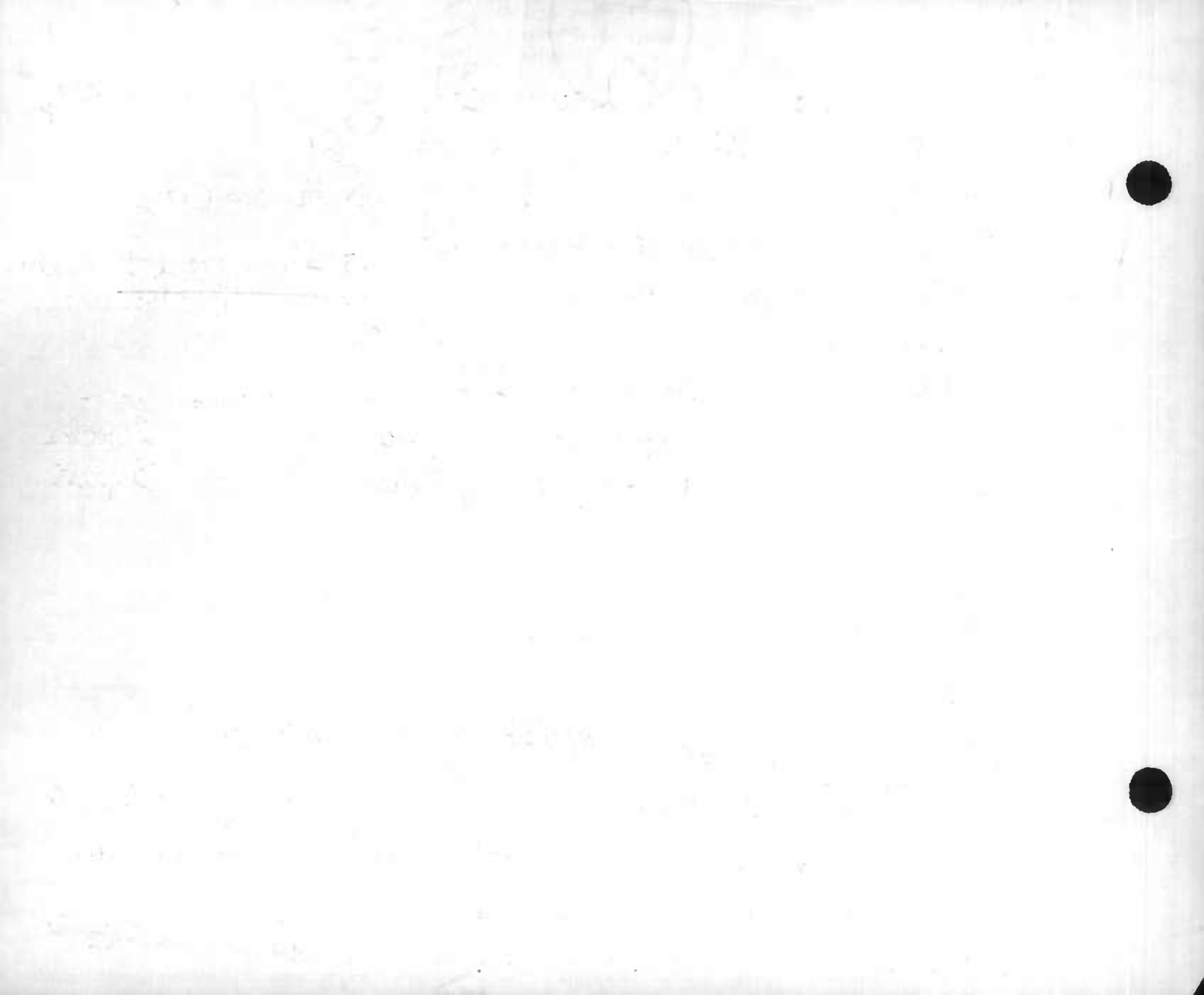
REG. NO.

|  |  |   |   |   |  |
|--|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Cora E Lawrence</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 12 84</b>  |   | 2b. HOUR<br><b>430</b> P.M.  |
| 3. SEX<br><b>F</b>   | 4. RACE<br><b>Black</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 24 23</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>61</b>  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>North Carolina</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Wyman Park Health System</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b> 13a. COUNTY <b>Baltimore</b> 13a. CITY OR TOWN <b>Baltimore</b>   |  |   | 13b. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Alvin Watson</b>  |  |   | 15. MOTHER'S NAME<br>FIRST MIDDLE LAST<br><b>Cora Williams</b>                                  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>241-32-3672</b>  |   | 17. INCOMPLETE ADDRESS<br><b>Alvin Lawrence 1537 Homestead St</b>                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Staphylococcus aureus sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Multiple Myeloma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 weeks</b><br><b>3 years</b>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.   |  |   |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>11/11/84</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>1819 Bolton St. Baltimore, MD</b> |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/11/84</b> 19____, to <b>11/12/84</b> 19____, that (I) (we) lost<br>saw the deceased alive on <b>11/12/84</b> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                      |  |   |   |   |  |
| 22b. SIGNATURE<br><b>D. Holcombe MD</b>  |  | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>11/12/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Holcombe, David</b>  |  | 22e. ADDRESS<br><b>1819 Bolton St. Baltimore, MD</b>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11-17-84</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Anne Arundel Co., Md.</b>   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Ave.</b>   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 15 1984</b>   |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, please notify injury, or other traumatic event, the medical examiner must be notified of this.



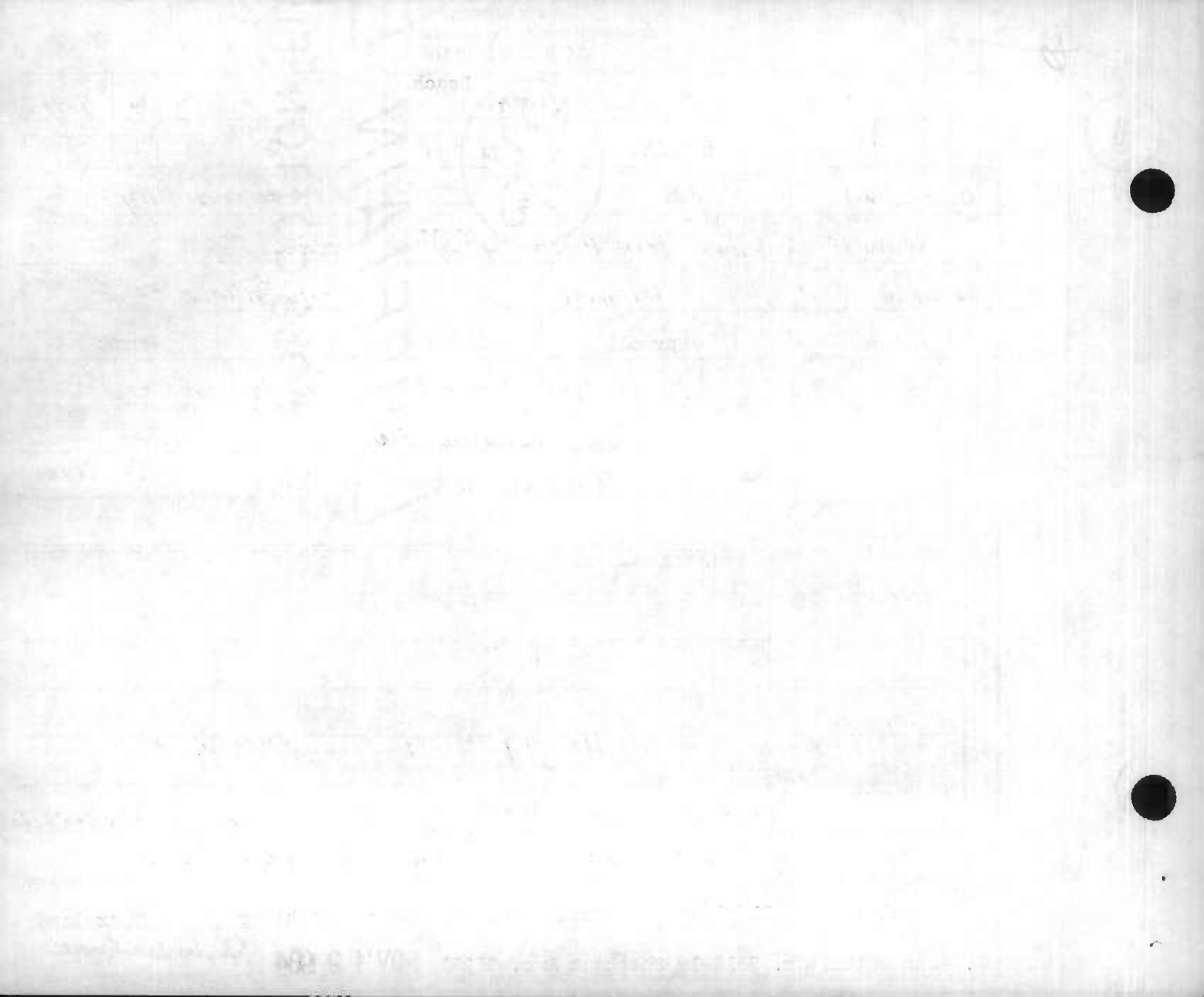
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE REGISTRAR   |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 84 30039   |  |  |  |
|---|--|--|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  | 2a. DATE OF DEATH  |  |  |  | 2b. HOUR  |  |  |  |
| FIRST MIDDLE LAST Leach   |  |  |  | MONTH DAY YEAR 11 17 84  |  |  |  | 1159p M   |  |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS.   |  |
| Female  |  | White  |  | MONTH DAY YEAR 12 30 05  |  | 78 YRS   |  | MONTHS DAYS   |  | HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |  |  |
| Georgia U.S.  |  | USA  |  |  |  | Baltimore City MD.   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Baltimore   |  | Lynmar Park Health System 21211  |  |  |  |  |  | Retired   |  |  |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS   |  |  |  |
| Maryland  |  | 1  |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | KESWICK 3429 Keswick Rd. 21211                                |  |  |  |
| 14. FATHER'S NAME   |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |   |  |  |  |
| FIRST MIDDLE LAST Lucius Parnell  |  |  |  | FIRST MIDDLE LAST Addie Lynn Hurst   |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS   |  |  |  |
| No  |  |  |  | 215-05-1540  |  | LARRY LEMAN  |  | 3431 KESWICK RD.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic Respiratory Arrest</u>  |  |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } b) <u>Catastrophic Intracerebral Process</u>   |  |  |  |  |  |  |  |   |  | 24-36 hrs  |  |
| DUE TO, OR AS A CONSEQUENCE OF c) _____   |  |  |  |  |  |  |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |  |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 7pm 11/17, 1984 to 1159pm 11/18/84, that (I) (we) last saw the deceased alive on above, (I) (we) (did) (did not) saw the body after death. |  |  |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE  |  |  |  | DEGREE   |  |  |  | 22c. DATE SIGNED  |  |  |  |
| Dr. D. Rodriguez  |  |  |  | M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>          |  |  |  | 11/18/84 00-30  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS   |  |  |  |   |  |  |  |
| Dr. D. Rodriguez  |  |  |  | Lynmar Park Health System  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| Burial  |  | 11/21/84   |  | Lorraine Park Cemetery   |  | Baltimore Maryland   |  |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME   |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |  |  |
| A. Alan Seitz, Jr. 3615-19 Chestnut Ave. 21211  |  |  |  | NOV 19 1984  |  | John Davidson-Randall  |  |   |  |  |  |





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 3 0 0 4 0

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |  |   |  |
|--|--|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Selma ELEANOR Lebowitz              |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11/26/84 |   |  | 2b. HOUR<br>11:33 AM  |  |
| 3. SEX<br>F FEMALE   |  | 4. RACE<br>CAUCASIAN  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 19 14   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br>WA  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>City MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Sinai HOSPITAL |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE                   |  |
| 13a. STATE<br>MD   |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Benjamin                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Henrietta HARRIS   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>APT. HOME  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No |  | 16b. SOCIAL SECURITY NO.<br>212 070 221   |   | 17. INFORMANT<br>MR. HAROLD PIPSICAS APT. 7A<br>3922 ROLLING RD. BALTO., MD 21208   |  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiac Arrest

DUE TO, OR AS A CONSEQUENCE OF

(b) MI vs PE w/ ruptured aneurysm

DUE TO, OR AS A CONSEQUENCE OF

(c) Atherosclerosis

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

COPD

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/23, 19 84, to 11/26, 19 84, that (I) (we) last saw the deceased alive on 11/26, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br>Steven Lerman   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>11/26/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Steven Lerman  |  |  |  | 22e. ADDRESS<br>3000 H Faltatt Manor Ct  |  |   |  |

|  |  |                            |  |  |  |  |  |
|--|--|----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b. DATE<br>NOV. 28, 1984 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>BALTIMORE HEBREW |  | 23d. LOCATION<br>BALTIMORE COUNTY MARYLAND |  |
| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS, INC.<br>6010 REISTERSTOWN RD. BALTO., MD 21215 |  |                            |  | 25. DATE REC'D BY MARYLAND REGISTRAR<br>DEC 3 1984     |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 3 0 0 4 1

REG. NO.


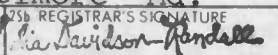
1- FOR  
STATE  
REGISTRAR

|  |  |   |   |  |  |  |   |  |   |  |
|--|--|---|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>BONNIE DAVENPORT LEE</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-26-84</b>  |  |  | 7b. HOUR<br><b>8:00</b><br>A M   |   |  |   |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>BLACK</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 17 19</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b><br>YRS.                                   |   | 7a. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Georgia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b><br>MD.                   |   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Georgia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b><br>MD.                   |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>LUTHERAN HOSPITAL</b> |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF EMPLOY FOR MOST OF WORKING LIFE)<br><b>Librarian</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Board of Educa. Balto. Md. 21215</b>   |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><b>MD</b>   |  |   | 13b. COUNTY<br><b>—</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                          |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>3127 SEQUOIA AVE</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Lovitt Davenport</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Willie Tramble</b>  |  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |   | 16b. SOCIAL SECURITY NO.<br><b>214-40-4821</b>  |  | 17. INFORMANT<br><b>Joseph R. Lee</b>                          |  | ADDRESS<br><b>Baltimore, Maryland 21215</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Anoxic Encephalopathy</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardiorespiratory arrest.</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Respiratory failure.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a   |  |   |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)         |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                      |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-12</b> , 19 <b>84</b> , to <b>11-26</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>11-26</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                    |  |   |   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>M. T. Duong</b>   |  |   | DEGREE<br><b>M.D.</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  | 22c. DATE SIGNED<br><b>11-26-84</b>  |   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>M. T. DUONG</b>  |  |   | 22e. ADDRESS<br><b>LUTHERAN HOSPITAL</b>  |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>12/1/1984</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hopeland Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Frederick, County, Maryland</b>                |  |   |  |
| 24. FUNERAL HOME OR<br>NAME ADDRESS<br><b>Nutter &amp; Sons 2501 Gwynns Falls Parkway<br/>Funeral Home Inc. Baltimore, Maryland 21216</b>  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 30 1984</b>   |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Jane W. Anderson-Mandall</b>                          |   |  |   |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH YOUR COPIES AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                         |  |   |   |   |  |   |   |  | REG. NO. 30042 |  |
|--|-------------------------|--|---|---|---|--|---|---|--|----------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CALVIN LEE</b>  |                         |  |   |   |   | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR <b>11 10 19 84</b> |   | 2b. HOUR <b>4:55 P</b>                                |  |                |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Black</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>May 11 49</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>35 YRS.</b> | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.   | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>11 10 19 84</b> | 7d. HOUR <b>4:55 P</b>   |   |   |  |                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto. Md.</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |   |   |  |                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Union Memorial Hospital</b> |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |  |                |  |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b>   |                         | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Balto.</b>  |   | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                     |   | 13e. STREET ADDRESS<br><b>524 E. 43 rd. St. 21214</b> |  |                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Lee</b>  |                         |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lillian Garrison</b>  |   |  |   |   |  |                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>No</b>  |                         | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES) <b>N/A</b>   |   | 17. INFORMANT ADDRESS<br><b>Lillian Lee 524 E. 43rd. St.</b>  |   |  |   |   |  |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple gunshot wounds (unspecified weapon)</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>Subject shot.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |                         |  |   |   |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |                         |  |   |   |   |  |   |   |  |                |  |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |                |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         | 21b. TIME OF INJURY<br>HOUR <b>3:56 P.M.</b> MONTH DAY YEAR <b>11-10- 19 84</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br><b>Subject shot.</b>   |   |  |   |   |  |                |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>home</b>   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>524 E. 43rd St., Balto. Baltimore Md.</b>   |   |  |   |   |  |                |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |  |   |   |   |  |   |   |  |                |  |
| ACTUAL SIGNATURE<br>  |                         | TITLE (SPECIFY)<br>M.D. <b>Assistant</b> MEDICAL EXAMINER  |   |   |   | DATE SIGNED <b>11-11-84</b>  |   |   |  |                |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Ann M. Dixon, M.D.</b>   |                         | ADDRESS <b>111 Penn St., Balto., Md. 21201</b>   |   |   |   |  |   |   |  |                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |                         | 23b. DATE<br><b>11-15-84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Balto. Cem.</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>   |   |   |  |                |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Ave.</b>   |                         |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 13 1984</b>   |   | 25b. REGISTRAR'S SIGNATURE<br>              |   |   |  |                |  |



20% COTTON LIBEL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |   |   |   |  |   |
|---|--|--|--|---|---|---|---|--|---|
| 1- FOR STATE REGISTRAR  |  |  |  |   | REG. NO.  |   |   |  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Calvin Calvin A. Lee Lee</b>   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>29</b> YEAR <b>84</b> 2b. HOUR <b>9:30 P.M.</b> |   |   |  |   |
| 3. SEX <b>M</b>   |  | 4. RACE <b>B</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>1</b> DAY <b>6</b> YEAR <b>29</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b> |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, DC</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |   |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF YOU KNOW FACILITY, GIVE STREET ADDRESS) <b>FRANCIS S. KEY MED. CTR.</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   | 13a. STREET ADDRESS / ZIP CODE  |   |   |  |   |
| 13a. STATE <b>MD</b>  |  | 13b. COUNTY <b>Baltimore</b>   |  | 13c. CITY OR TOWN <b>Baltimore</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br><b>2500 E. Madison St. 21205</b>           |   |
| 14. FATHER'S NAME<br>FIRST <b>Amos</b> MIDDLE <b></b> LAST <b>Lee</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Pearl</b> MIDDLE <b></b> LAST <b>Kelly</b>             |   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>578-28-4925</b>   |  | 17. INFORMANT<br><b>Linda Sanders</b>   |   | ADDRESS <b>Alexandria, VA</b><br><b>911 N. Alford St. 22314</b>                                 |   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>pulmonary decompensation</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Diabetes, HTN, CRF</b>                  |  |  |  |   |   |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>  |  |  |  |   |   |   |   |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                   |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |   |   |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |   |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |   |   |  |   |
| 22b. SIGNATURE <b>Charles Wandt</b> DEGREE  |  |  |  |   | 22c. DATE SIGNED <b>11-29-84</b>  |   |   | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Charles Wandt</b>                   |   |
| 22e. ADDRESS <b>TSK MC</b>  |  |  |  |   |   |   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>12/5/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Garrison Forest Va</b>  |   | 23d. LOCATION<br>CITY OR TOWN <b>Owings Mills</b> COUNTY <b></b> STATE <b>MD</b>                |   |  |   |
| 24. FUNERAL DIRECTOR<br>NAME <b>Wm. C. March F/H</b> ADDRESS <b>1101 E. North Ave.</b>  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR <b>DEC 4 1984</b>   |   | 25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>  |  |   |





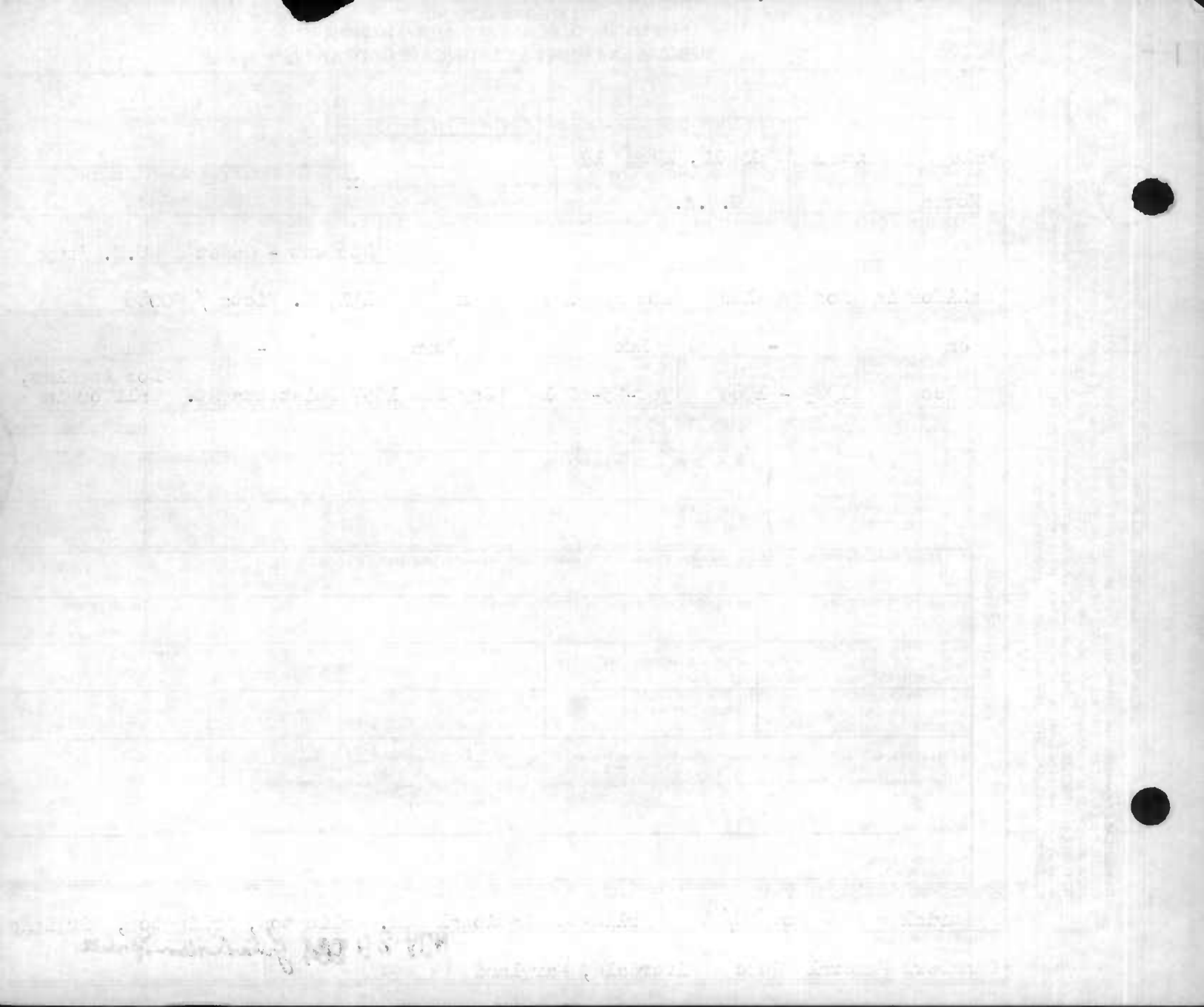
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 8

REG. NO. 30004

1- FOR  
STATE  
REGISTRAR

|  |                          |  |   |   |  |   |   |   |
|--|--------------------------|--|---|---|--|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Daniel J Lee</b>   |                          |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>11/22/84 |   |  | 2b. HOUR<br>M<br>3:11A  |   |   |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Korean</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 12, 1965</b>   | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br><b>19 YRS.</b>  | IF UNDER 1 YR.<br>MONTHS DAYS<br><b>0 0</b>   | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>0 0</b>   | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>11/22/84</b>                           |   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Korea</b>  |                          | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                       |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                          | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital</b> |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Student - Cadet</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Army</b> |
| 13a. STATE<br><b>California</b>  |                          |  | 13b. COUNTY<br><b>Los Angeles</b>   | 13c. CITY OR TOWN<br><b>Los Angeles</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                | 13e. STREET ADDRESS<br><b>1317 N. Vista / 90046</b>                                     |   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Jay - Lee</b>   |                          |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sora - Chung</b>                                |   |  |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>Yes</b>  |                          | (IF YES, GIVE WAR OR DATES)<br><b>1983 - 1984</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>568-25-6261</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Jay Lee 1557 Poinsetta St. Los Angeles, California</b>   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cranio cerebral trauma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: <b>8151</b>   |                          |  |   |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH          |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |                          |  |   |   |  |   |   |   |
| 19a. DATE OF OPERATION   |                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                          |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>11:50PM 11/21/84</b>                          |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Passenger in auto/fixed objects impact</b> |   |   |   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                          |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>highway</b>                       |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>Balto/WashPkwy, Big Patuxent Bridge, ACo, MD</b>                       |   |   |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                          |  |   |   |  |   |   |   |
| ACTUAL SIGNATURE<br><b>[Signature]</b>   |                          |  | TITLE (SPECIFY)<br><b>Assistant</b> MEDICAL EXAMINER  |   |  |   | DATE SIGNED<br><b>11.22.84</b>  |   |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Gregory R. Kauffman, MD.</b>   |                          |  | ADDRESS<br><b>111 Penn Street, Balto. MD 21201</b>  |   |  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |                          |  | 23b. DATE<br><b>Nov/28/84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National Cem</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arlington, Arlington, Virginia</b> |   |
| 24. FUNERAL DIRECTOR NAME<br><b>Chambers Funeral Home</b>  |                          |  | ADDRESS<br><b>Riverdale, Maryland</b>   |   |  | NOV 29 1984 <b>[Signature]</b>  |   |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 3 0 0 4 5

REG. NO.

|   |  |  |  |   |  |  |   |   |  |  |
|---|--|--|--|---|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ELEANOR FRANCES LEE</b>   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>NOVEMBER 30, 1984</b>           |   |  | 2b. HOUR<br><b>6:45 A M</b>  |   |   |  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>BLACK</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JUNE 29 1901</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b> YRS                                     |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 72 HRS<br>HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US of A</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD                     |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>PROVIDENT HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>DOMESTIC</b>  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><b>MARYLAND</b>  |  |  | 13b. COUNTY<br><b>BALTIMORE</b>  |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                      |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>WALTER E. LEE</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>JANNIE JACKSON</b> |   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>4804 HADDON AVENUE 21207</b>                    |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |  | 16b. SOCIAL SECURITY NO<br><b>183 22 6540</b>                          |   | 17. INFORMANT ADDRESS<br><b>MRS. EDITH BOOKER 4804 HADDON AVENUE 21207</b> |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>Chronic Renal Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Congestive heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 yrs</b><br><b>2 yrs</b><br><b>10 yrs</b>                               |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.  |  |  |  |   |  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN IDENTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)        |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/29/84</b> to <b>11/30/84</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Elisabeth Sanderson</b> M.D.<br>22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |   |  | 22c. ADDRESS<br><b>2 H2 mill R.D. BALTO MD 21207</b>                                 |   | 22e. DATE SIGNED<br><b>12/2/84</b>  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  |  | 23b. DATE<br><b>12/3/84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ARBUTUS MEMORIAL PARK</b>         |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE (BALTO.) MD.</b>                     |   | 23e. DATE REC'D. BY REGISTRAR 23f. REGISTRAR'S SIGNATURE<br><b>NFC 4 1984</b> <b>Shelia Davidson-Randall</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>LEWIS T. GWENN</b> ADDRESS<br><b>4517 PARK HEIGHTS AVENUE</b>  |  |  |  |   |  |  |   |   |  |  |

X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 3 0 0 4 6

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |  |   |  |  |  |                        |  |
|---|--|--|--|--|---|--|--|--|------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>WALTON M. LEE  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11/5/84                         |  |   | 2b. HOUR<br>11:04 AM   |  |  |                        |  |
| 3. SEX<br>male  |  | 4. RACE<br>Black   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 13 96   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>87  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |  |                        |  |
| 10. CITY OR TOWN OF DEATH<br>Hd City  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>LUTHERAN HOSPITAL |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE WORK FOR MOST OF WORKING LIFE)<br>Retired Nurse   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |                        |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br>Md.   |  |  | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>2920 Cucumber Cwe-                  |  | 13f. ZIP CODE<br>21216 |  |
| 14. FATHER'S NAME<br>JESSE LEE  |  |  | 15. MOTHER'S MAIDEN NAME<br>AUGUSTA MATTHEWS                           |  |   |  |  |  |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  |  | 16b. SOCIAL SECURITY NO.<br>220 092 560                                |  | 17. INFORMANT<br>June White 1705 Swannsea Road  |  |  |  |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) SEPTIC SHOCK<br>DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA<br>DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)   |  |  |  |  |   |  |  |  |                        |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |  |                        |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/5, 1984, to 11/5, 1984, that (I) (we) last saw the deceased alive on 11/5, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |  |  |  |                        |  |
| 22b. SIGNATURE<br>Ludovina L. Cueto   |  |  | DEGREE   |  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>11/5/84  |                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>LEDUVINA L. CUETO  |  |  | 22e. ADDRESS<br>LUTHERAN HOSPITAL                                      |  |   |  |  |  |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |  | 23b. DATE<br>11/8/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Nat'l   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore MD |  |                        |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H 1101 E. North Ave.   |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 7 1984   |  | 25b. REGISTRAR'S SIGNATURE<br>Jolia Davidson-Rendell       |  |                        |  |

BP.

No. 11

353

m

25-10-1914



50% COTTON



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |              |  |   |  |                                  |   |
|---|--|---|--|---|--------------|--|---|--|----------------------------------|---|
| FOR<br>STATE<br>REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br>Anna   | MIDDLE<br>M. | LAST<br>LEFKOWSKI  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 16 84 |  | 2b. HOUR<br>5 <sup>26</sup> A.M. |   |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept. 5 1950  |              | 6. AGE (IN YEARS LAST BIRTHDAY)<br>34 YRS  |   | IF UNDER 1 YEAR<br>MONTHS DAYS   |                                  | IF UNDER 24 HRS<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Penna.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |   |  |                                  |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University of Md. Hospital |  |   |              | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Clerk            |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>City Gov'T.   |                                  |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  | 13a. STATE<br>Md.   |              | 13b. COUNTY<br>Balto.  |   | 13c. CITY OR TOWN<br>Balto.  |                                  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John J. Lefkowski   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Bertha Ruthford  |              |  |   | 16. STREET ADDRESS / ZIP CODE<br>1718 Linden Ave. 21217  |                                  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No.   |  |   |  | 16b. SOCIAL SECURITY NO.<br>208-38-6242   |              | 17. INFORMANT<br>ADDRESS<br>Hoffman-Roth F. H. Carlisle, Pa.                         |   |  |                                  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>REFRACTORY ACUTE NON-LYMPHOBLASTIC LEUKEMIA</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |  |   |              |  |   |  |                                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |   |  |   |              |  |   |  |                                  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |              | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)  |              |  |   |  |                                  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |              |  |   |  |                                  |   |
| 22a. I certify that (the hospital) attended the deceased from <u>11/8/84</u> to <u>11/16/84</u> , that (I) (we) lost <u>see the deceased alive on 11/16</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we which did not view the body after death.)  |  |   |  |   |              |  |   |  |                                  |   |
| 22b. SIGNATURE<br>T. McMullen M.D.  |  | DEGREE  |  | 22c. DAY SIGNED<br>11/16/84   |              |  |   | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>T. McMullen M.D.  |                                  |   |
| 22e. ADDRESS<br>University Of Md. Hospital  |  | 22f. ADDRESS  |  |   |              |  |   |  |                                  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Removal-Burial  |  | 23b. DATE<br>11-16-84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Westminister  |              | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Carlisle Pa                            |   | 23e. DATE REC'D. BY REGISTRAR<br>NOV 19 1984   |                                  |   |
| 24. REMOVAL DIRECTOR<br>NAME<br>H. W. Jenkins & Sons Co., Balto., Md.   |  | ADDRESS   |  |   |              |  |   |  |                                  |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |   | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |   | 8 4 3 0 0 4 8  |  |
|--|---|---|---|--|--|
| GLADYS M. LEIBIG   |   | CERTIFICATE OF DEATH  |   | REG. NO.   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Gladys M. Leibig</b>   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11-7-84</b>  |  | 2b. HOUR<br><b>5:00 AM</b>   |
| 3. SEX<br><b>FEMALE</b>  | 4. RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>5-3-18</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS.                                    | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Mercy Hospital</b> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>               |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>   |   | 13b. CITY OR TOWN<br><b>A.A.</b>  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13d. STREET ADDRESS<br><b>113A Elm Ave, 21061</b>                                    |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Walter Fike</b>  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Martha Savage</b>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>218 16 2731</b>  |   | 17. INFORMANT ADDRESS<br><b>Dawn Bafford same as 13 e</b>                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic bronchogenic carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Obstructive pneumonia 2° to 1</b>   |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)        |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/7/84</b> 19 to <b>11/7</b> 19 <b>84</b> that (I) (we) lost saw the deceased alive on <b>11/7</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Marie Amos Dobyns</b>   |   |   |   | 22c. DATE SIGNED<br><b>11/7/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARIE AMOS DOBYNS</b>  |   |   |   | 22e. ADDRESS<br><b>201 St Paul Place Balto.</b>                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |   | 23b. DATE<br><b>11/10/84</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>                                |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Brooklyn A.A. Md.</b>  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br><b>George J. Gonc 4001 Ritchie gwy</b>  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 9 1984</b>  |  |  |
|  |   |   | 25b. REGISTRAR'S SIGNATURE<br><i>Wanda Rando</i>  |  |  |

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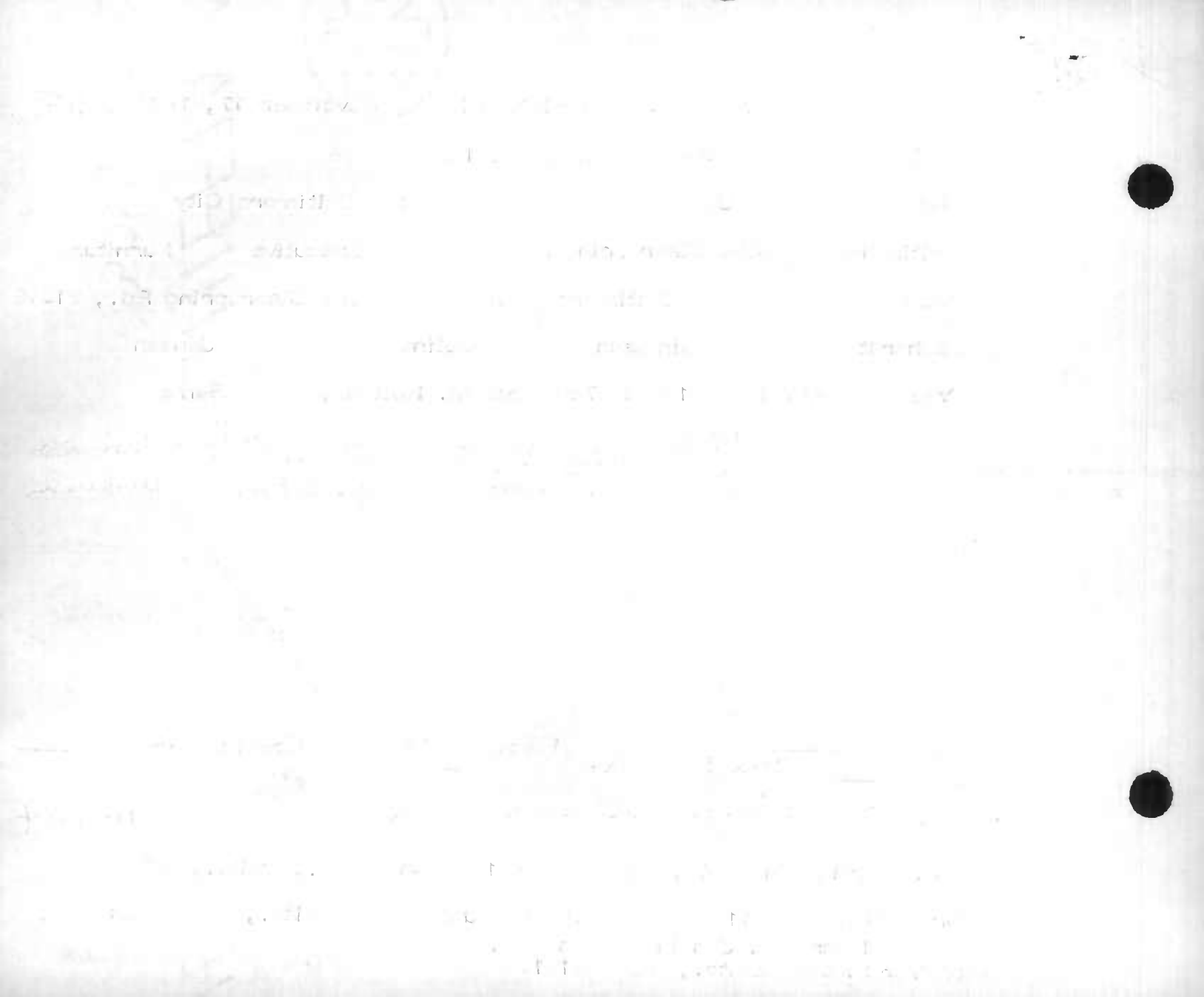
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of price.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |   |  |  |  |  |
|---|--|---|--|---|---|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   | REG. NO.  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>MILTON W. LEIMBACH  |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>November 17, 1984 |  |  | 2b. HOUR<br>11:55 AM   |  |
| 3 SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>May 24, 1898   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>86 YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>6008 Clearspring Road |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Executive   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Furniture   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>MD  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br>6008 Clearspring Rd., 21212  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Gephardt Leimbach  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Adeline Jensen  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes  |  |   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>WW I 218 32 2740  |   | 17. INFORMANT ADDRESS<br>Iva M. Holland, Same  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one code per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE TO (a) <u>① Atherosclerotic Coronal Artery Disease - Congestive Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>② Cerebral Sclerosis with multiple CVA's</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>unknown</u><br><u>unknown</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____  |  |   |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |   |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>Feb 21, 1983</u> to <u>Nov. 17, 1984</u> , that (I) (the hospital) saw the deceased alive on <u>June 3, 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.  |  |   |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><u>Martin Singewald</u>   |  |   |  | DEGREE<br>M.D.  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>11-19-84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Martin Singewald, MD   |  |   |  | 22e. ADDRESS<br>11 E. Chase St., Balto., MD   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation  |  | 23b. DATE<br>11/20/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Mount   |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Balto., MD  |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., MD   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 19 1984  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Rodden</u>   |  |  |  |

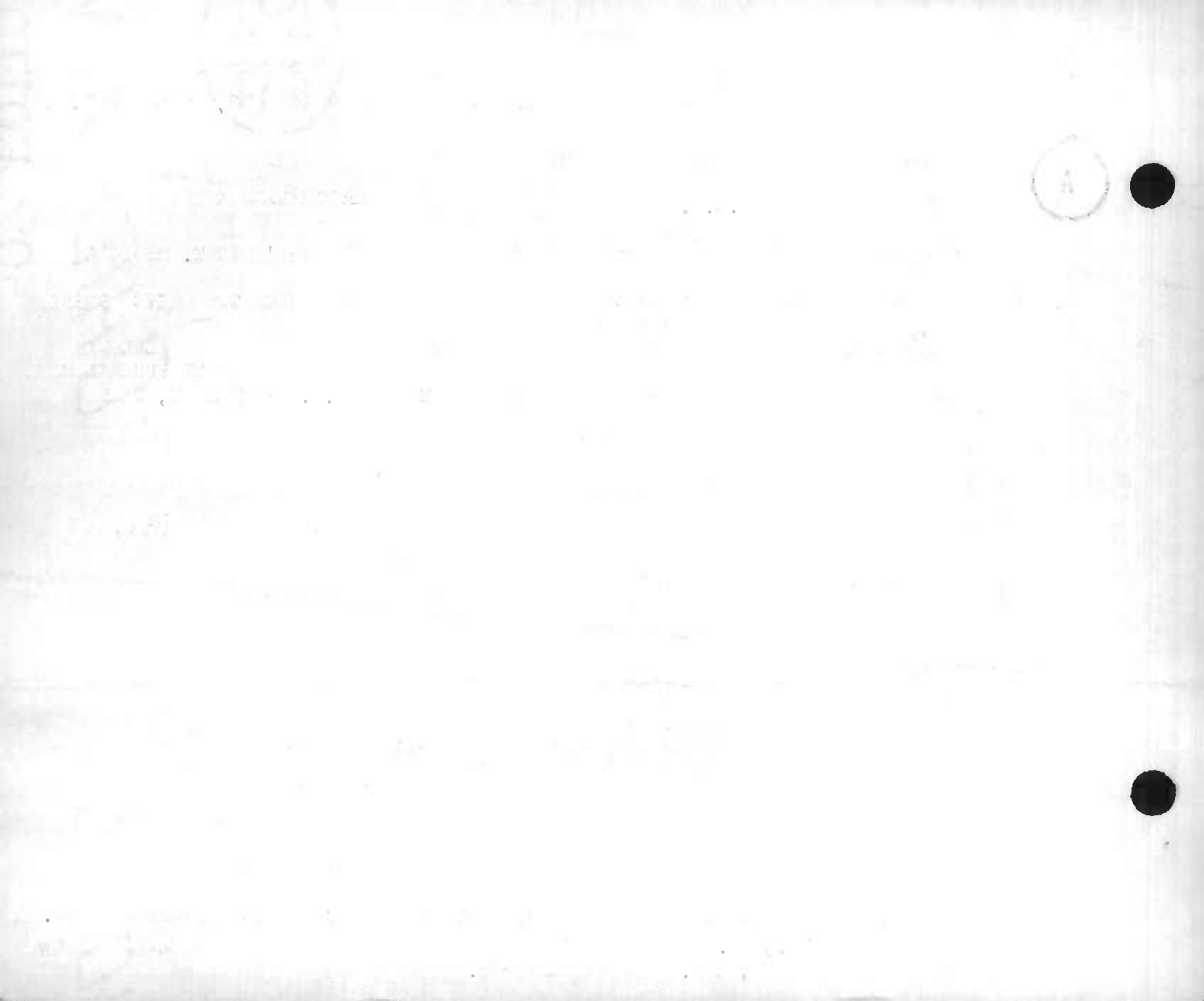


STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1- FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH   |   | 2b. HOUR   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | MONTH DAY YEAR  |   | P M  |  |
| BARBARA L LEMME   |  | NOVEMBER 25, 1984   |   | 11:00 AM   |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)                               | IF UNDER 1 YEAR  |  |
| FEMALE  | WHITE  | MONTH DAY YEAR  | 25 YRS  | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |  |  |
| NEW YORK  | U.S.A.   |   | BALTIMORE CITY MD.  |  |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| BALTIMORE   | JOHNS HOPKINS HOSPITAL   |   | PHYSICIAN'S ASST  |  | MEDICAL  |
| 13a. STATE  |  | 13b. COUNTY   | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?   |  |
| FLORIDA   | PASCO  | NEW PORT  | YES <input type="checkbox"/> NO <input type="checkbox"/>      | 13e. STREET ADDRESS / ZIP CODE   |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |   | ADDRESS  |  |
| FIRST MIDDLE LAST   |  | FIRST MIDDLE LAST   |   | NORTH FUNERAL HOME   |  |
| LAWRENCE WEEDEN   |  | SANDY BALDWIN   |   | FLORIDA  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT  |  |
| NO  |  | 049-52-5227   |   | KIM ESAREY 2508 U.S.19; HOLIDAY, FLORIDA                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiorespiratory arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>premature</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>immune compromise 2° BMT and AMU</u>   |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 hour</u><br><u>4 days</u><br><u>18 days</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:<br><u>recurrent acute myocardial ischemia</u>  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?  |  |
|   |  |   |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NO: WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (1) this hospital attended the deceased from <u>11/7</u> , 19 <u>84</u> , to <u>11/25</u> , 19 <u>84</u> , that (1) (we) lost saw the deceased alive on <u>11/25</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did (did not) view the body after death. |  |   |   |  |  |
| 22b. SIGNATURE  |  | DEGREE  |   | 22c. DATE SIGNED   |  |
| <u>Dr. J. McGuire</u>   |  | MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |   | 11/26/84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |   |  |  |
| Maureen J McGuire   |  | Johns Hopkins Hospital  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| CREMATION   |  | 11-30-84  |   | SECURITY PROCESS   |  |
| 24. FUNERAL DIRECTOR NAME   |  | 24b. ADDRESS  |   | 25a. DATE REC'D BY REGISTRAR   |  |
| BALTO., MD.   |  | 21229   |   | NOV 30 1984  |  |
| HUBBARD FUNERAL HOME, INC.  |  | 4107 WILKENS AVE.   |   | 25b. REGISTRAR'S SIGNATURE   |  |
|   |  |   |   | <u>Haroldson-Randall</u>   |  |





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

3 0 0 5 1

1- FOR  
STATE  
REGISTRAR

|  |   |   |   |  |
|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Ethel Levenson  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 5 84  |   | 2b. HOUR<br>11:45 A.M.   |
| 3. SEX<br>FEMALE   | 4. RACE<br>WHITE  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 12 01   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>83 YRS.                           |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>CITY OF BALTIMORE MD.        |
| 10. CITY OR TOWN OF DEATH<br>baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SINAI HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE                   | 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME                         |
| 13a. STATE<br>MARYLAND   | 13b. COUNTY<br>BALTIMORE  | 13c. CITY OR TOWN<br>BALTIMORE  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>APT. 203<br>7219 PARK HEIGHTS AVE. 21208      |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>SAMUEL CAPLAN  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ANNA JACOBS  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO |   | 16b. SOCIAL SECURITY NO.<br>214-46-9779   |   | 17. INFORMANT<br>ADDRESS<br>APT. 203<br>7219 PARK HEIGHTS AVE. 21208 |

## 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

Chronic

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

|   |  |   |   |
|---|--|---|---|
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/29 19 84 to 11/5 19 84, that (I) (we) last saw the deceased alive on 11/5 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |
| 22b. SIGNATURE<br>Rhonda Zuckerman MD   | DEGREE   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br>11/5/84   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Rhonda Zuckerman   |  | 22e. ADDRESS<br>Sinai Hosp  |   |

|  |                      |   |  |
|--|----------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   | 23b. DATE<br>11/6/84 | 23c. NAME OF CEMETERY OR CREMATORY<br>BNAT ISRAEL CEM | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND |
| 24. FUNERAL DIRECTOR<br>NAME<br>SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD. BALTIMORE MARYLAND 21215 |                      | 25a. DATE REC'D. BY REGISTRAR<br>NOV 13 1984          |  |
|  |                      | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randall   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

11 12 2 11

normal

1913

28

10

P

W

A 20

at 1000 ft. - 1000 ft. - 1000 ft.

at 1000 ft. - 1000 ft. - 1000 ft.

at 1000 ft. - 1000 ft. - 1000 ft.

1913

GN

1000

1000



1913

1913

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITHIN THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

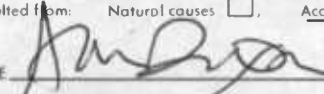
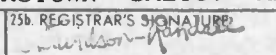
BP  
DHMH - 17  
(VR A15 ME (5))  
20M 4/B2

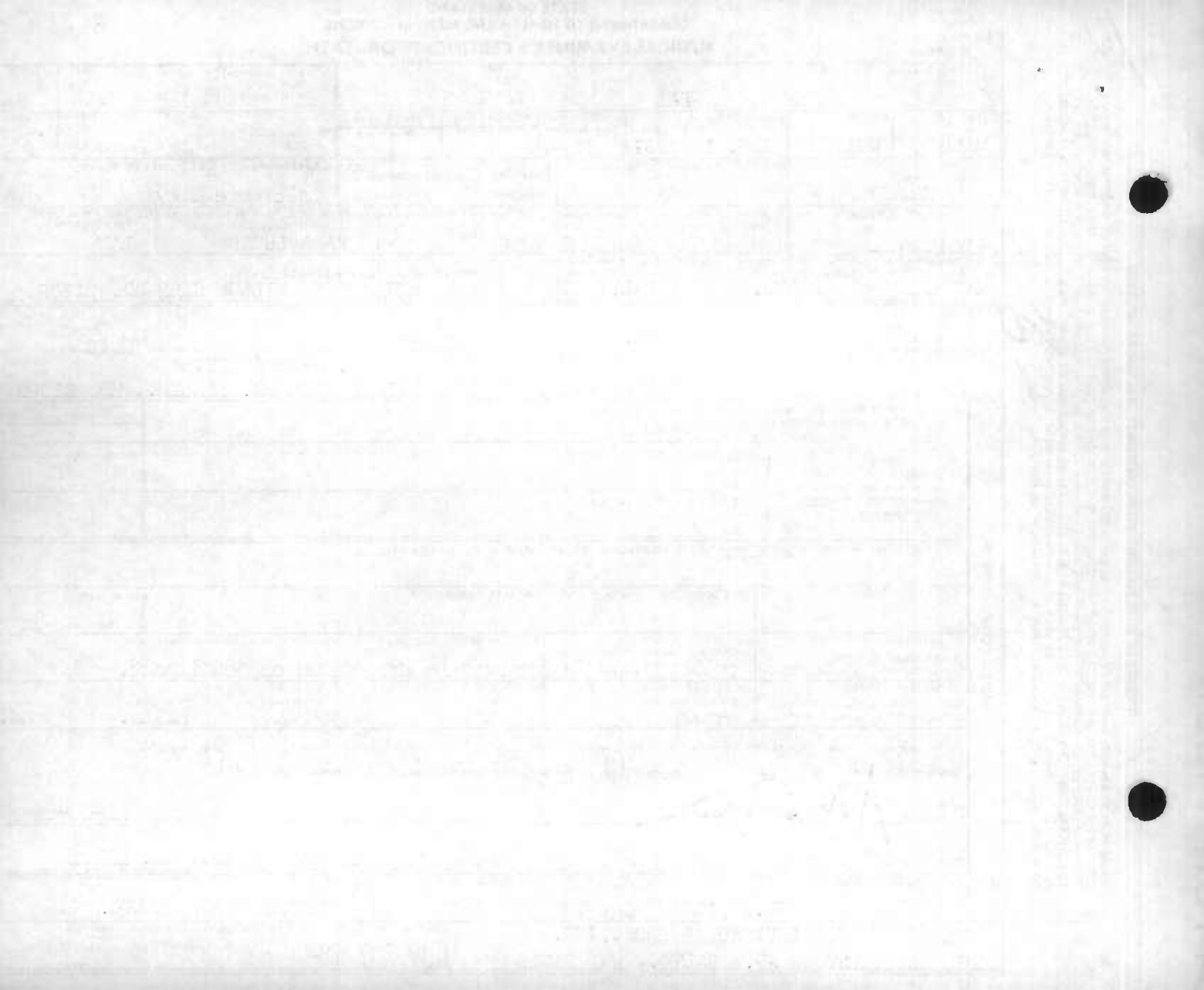
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

30052

1- FOR  
STATE  
REGISTRAR

|  |                              |  |   |   |  |   |   |   |
|--|------------------------------|--|---|---|--|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>LARRY NEAL LEVIN</b>   |                              |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>11 9 1984</b> |   |  | 2b. HOUR<br><b>6:54 P M</b>   |   |   |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>WHITE</b>      | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>AUG. 10, 1957</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>27 YRS.</b>   | IF UNDER 1 YR.<br>MONTHS DAYS<br><b>0 0</b>   | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>0 0</b>             | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>11 9 1984</b>  |   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |                              | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                              | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital (STU)</b> |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>PARA LEGAL</b>                                  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>LAW</b> |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |                              |  |   |   |  |   |   |   |
| 13a. STATE<br><b>MARYLAND</b>  | 13b. COUNTY<br><b>BALTO.</b> | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 13e. STREET ADDRESS<br><b>2606 WILLOW GLEN DR. 21209</b> |   |   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JEROME LEVIN</b>  |                              |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>KITTY THEIS</b>   |  |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>NO</b>   |                              | 16b. SOCIAL SECURITY NO.<br><b>213-48-6082</b>   |   | 17. INFORMANT<br><b>MR. JEROME LEVIN</b><br><b>2606 WILLOW GLEN DR. BALTO., MD 21209</b>  |  |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>8150 IMMEDIATE CAUSE (a) Multiple injuries</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |                              |  |   |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH    |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):  |                              |  |   |   |  |   |   |   |
| 19a. DATE OF OPERATION   |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   |  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                              | 21b. TIME OF INJURY<br>HOUR MONTH DAY YEAR<br><b>2 P.M. 11-4- 19 84</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br><b>Driver in auto/fixed object impact.</b>                                 |  |   |   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |                              | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>road</b>   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>Hillside &amp; Cottage Rd. Balto. Md.</b>   |  |   |   |   |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |                              |  |   |   |  |   |   |   |
| ACTUAL SIGNATURE<br>  |                              | TITLE (SPECIFY)<br>M.D. <b>Assistant</b>   |   |   | MEDICAL EXAMINER   |   | DATE SIGNED <b>11-10-84</b>   |   |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Ann M. Dixon, M.D.</b>  |                              | ADDRESS <b>111 Penn St., Balto., Md. 21201</b>   |   |   |  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |                              | 23b. DATE<br><b>NOV. 11, 1984</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE HEBREW</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>REISTERSTOWN BALTO. MD</b>   |   |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>SOL LEVINSON &amp; BROS., INC.<br/>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |                              |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 20 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br> |   |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| Item 13e per phone 11/28/84 dad STATE OF MARYLAND   |  |  |  |   |  |  |  |  |  |
|---|--|--|--|---|--|--|--|--|--|
| 1 - STATE REGISTRAR   |  |  |  |   |  |  |  |  |  |
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |   |  |  |  |  |  |
| CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |  |  |
| REG. NO. 4 30053  |  |  |  |   |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Littlejohn Baby Boy</b>  |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 2 84</b>  |  | 2b. HOUR<br><b>8:00 PM</b>   |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>BLACK</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 2 84</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>1m 2m 11d</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>1 35</b>  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balt. City</b> MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Univ of Maryland</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Baby</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Baltimore</b>   |  |  |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>1710 W. Franklin St. 21223</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>unknown</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Barette Littlejohn</b>  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>non</b>   |  | 17. INFORMANT ADDRESS   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>severe prematurity</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>—</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>   |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>N/A</b>   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-2</b> , 19 <b>84</b> , to <b>11-2</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>11-2</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                  |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Donna Snyder MD</b>  |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11-2-84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Donna Snyder</b>  |  |  |  |   |  | 22e. ADDRESS<br><b>22 S. Greene St. Balt. Md</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Removal</b>  |  | 23b. DATE<br><b>11/15/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Anatomy Board</b>  |  |  |  |   |  | ADDRESS<br><b>Balto., Md.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 16 1984</b>  |  |
|   |  |  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |  |  |

WOOD M

93875 MOT



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 3 0 0 5 4

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>NORMAN LOBDELL</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11/15/84 11/15/84 1984</b>                       |  | 2b. HOUR<br><b>100A</b>  |
| 3. SEX<br><b>male</b>  | 4. RACE<br><b>white</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 11 21</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b>                                   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.Y.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.              |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Warehouse Mang.</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>E.I.L. Instruments</b>   |
| 13a. STATE<br><b>MD</b>  |  |   | 13b. CITY OR TOWN<br><b>Baltimore</b>  | 13c. STREET ADDRESS<br><b>3590 Dudley Ave</b>                                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James R. Lobdell</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Edith R. Main</b>                      |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>yes. WWII</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>213-18-7830</b>  | 17. INFORMANT ADDRESS<br><b>Ruth Lobdell 3590 Dudley Avenue 21213</b>                      |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respirator Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>chronic obst. Pul disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>&gt; 10 years</b>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)<br><b>ASTHMA</b>  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Richard R. Jones</b>  |  |   |  | DEGREE<br><b>MD</b>  | 22c. DATE SIGNED<br><b>11/15/84</b>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RICHARD R. JONES</b>   |  |   |  | 22e. ADDRESS<br><b>SINAI Hospital</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>11-17-84</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Md.</b>                       |  |
| 24. FUNERAL DIRECTOR<br><b>Schimunek Funeral Home, Inc.</b><br><b>8331 Brehms Lane, Balt., Md. 21213</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 19 1984</b>                            | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>   |

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

157-8-101-1-1-1

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157-8-101-1-1-1

157-8-101-1-1-1

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157-8-101-1-1-1

157-8-101-1-1-1



157-8-101-1-1-1

157-8-101-1-1-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called and a report filed.STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

84 30055

1- STATE  
REGISTRAR

REG. NO.

|  |  |   |   |  |                            |   |
|--|--|---|---|--|----------------------------|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Harry Jacob Lober</i>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>10-2-84</i> |  | 2b. HOUR<br><i>6:35 PM</i> |   |
| 3. SEX<br><i>Male</i>  | 4. RACE<br><i>Caucasian</i>                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>3-6-03</i>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>81</i>   |                            | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                  |
| 7a. BIRTHPLACE<br>(COUNTRY)<br><i>Maryland</i>   | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                    |                            |   |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore, MD</i>                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>South Baltimore General Hospital</i>        |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Ret. None</i> |                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Machinist/ F.M.C.</i> |
| 13a. STATE<br><i>MD</i>  |  | 13b. CITY OR TOWN<br><i>Baltimore</i>   |   | 13c. STREET ADDRESS / ZIP CODE<br><i>700 E. Maple Rd 21090</i>                       |                            | <i>21219</i>  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Unknown John Henry Lober</i>              |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Unknown Clara Elizabeth Minster</i>   |   |  |                            |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>Unknown</i> |  | 16b. SOCIAL SECURITY NO.<br><i>213-01-9506</i>  |   | 17. INFORMANT<br>NAME ADDRESS<br><i>Eleanor J. Lober Same as #13</i>                 |                            |   |

18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a).

*Cardiopulmonary Arrest*

DUE TO, OR AS A CONSEQUENCE OF

*Severe Congestive Heart Failure and  
Atherosclerotic Heart Disease*

DUE TO, OR AS A CONSEQUENCE OF

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>10-6</i> , 19 <i>84</i> , to <i>11-2</i> , 19 <i>84</i> , that (I) (we) lost<br>saw the deceased alive on <i>11-2</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) sign the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><i>D. Buck MD</i>  |  |  |  | DEGREE  |  | 22c. DATE SIGNED<br><i>11-2-84</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>D. Buck</i>  |  |  |  | 22e. ADDRESS<br><i>South Baltimore General Hospital</i>                       |  |   |  |

|   |  |                               |  |  |  |   |  |
|---|--|-------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>11/6/1984</i> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Cedar Hill Cemetery</i> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Balto., A. A. Co., Md.</i> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>McGully Funeral Homes 237 E. Patapsco Ave., Balto., Md., 21225</i> |  |                               |  | 25a. DATE REC'D. BY REGISTRAR<br><i>NOV 5 1984</i>               |  | 25b. REGISTRAR'S SIGNATURE<br><i>John Davidson</i>                          |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 12 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (S))

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                         |  |  |   |                                |  |   |   |  | REG. NO. |  |
|---|-------------------------|--|--|---|--------------------------------|--|---|---|--|----------|--|
| 1- FOR STATE REGISTRAR<br>1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>CHARLES UPSON LOGAN</b>  |                         |  |  |   |                                | 2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> 11/26 1984           |   | 2b. HOUR M  |  |          |  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Sept. 28 1954 30 YRS.</b>  | 6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS HOURS MIN.<br><b>30 YRS.</b>     | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS.<br>HOURS MIN. | 7c. DATE PRONOUNCED DEAD<br><b>12-1-84</b>   |   | 7d. HOUR<br><b>1:19A</b>  |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Kentucky</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD                             |   |   |  |          |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NONE, GIVE FACTORY, STREET, ADDRESS)<br><b>3618 Kimble Road</b> |  |   |                                | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Production Mgr.</b>      |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Publishing</b>  |  |          |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |                         |  |  |   |                                |  |   |   |  |          |  |
| 13a. STATE<br><b>Md.</b>  |                         | 13b. COUNTY<br><b>Balto.</b>   |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |                                | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>3618 Kimble Rd.</b>   |  |          |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>D. Covington Logan</b>  |                         |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Carol Upson</b>  |                                |  |   |   |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br><b>No</b>   |                         | (IF YES, GIVE WAR OR DATES)  |  | 16b. SOCIAL SECURITY NO.  |                                | 17. INFORMANT ADDRESS<br><b>D. C. Logan Louisville, Ky.</b>                                  |   |   |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute carbon monoxide intoxication</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |                         |  |  |   |                                |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I  |                         |  |  |   |                                |  |   |   |  |          |  |
| 19a. DATE OF OPERATION  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |   |                                |  |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br><b>11PM 11-26-84</b>  |                         |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>11PM 11-26-84</b>         |   |                                |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br><b>subject found in car with ignition on</b> |  |          |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>garage</b> |   |                                | 21f. LOCATION<br><b>3618 Kimble Road Baltimore, Maryland</b> STATE                           |   |   |  |          |  |
| 22a. I certify that the body of the deceased described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                         |  |  |   |                                |  |   |   |  |          |  |
| ACTUAL SIGNATURE<br><i>Thomas D. Smith</i>  |                         |  | TITLE (SPECIFY)<br><b>M.D. Deputy Chief</b>                                  |   |                                |  |   | DATE SIGNED<br><b>12-1-84</b>   |  |          |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Thomas D. Smith, M.D.</b>   |                         |  | ADDRESS<br><b>111 Penn Street</b>  |   |                                |  |   |   |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |                         | 23b. DATE<br><b>12/3/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount</b>  |                                |  | 23d. LOCATION CITY OR TOWN<br><b>Balto.,</b> STATE<br><b>MD</b> |   |  |          |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Henry W. Jenkins &amp; Sons Co., Balto., Md.</b>  |                         |  |  |   |                                | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 4 1984</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |          |  |



1918

W. J.

Date

24th March 1918

D.

John - Logan

Chief

London

No

D. C. Logan

London

W. J.



W. J. Logan, 24th March 1918

W. J. Logan, 24th March 1918

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 4 3 0 0 5 7

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |  |   |
|---|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Bertha</i> <i>Lozinsky</i>   |  |   | 2a. DATE OF DEATH<br>MONTH <i>11</i> DAY <i>16</i> YEAR <i>84</i>                               |  | 2b. HOUR<br><i>8:05</i><br>P.M.                     |
| 3. SEX<br><i>Female</i>   | 4. RACE<br><i>White</i>  | 5. DATE OF BIRTH<br>MONTH <i>07</i> DAY <i>11</i> YEAR <i>11</i>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>73</i> YRS   |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><i>WASHINGTON, D.C.</i>   | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                            |   |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Sinai Hospital</i> |   | 12a. USUAL OCCUPATION<br>(TYPE OF BUSINESS, TRADE, OR WORKING LIFE)<br><del>HOUSEWIFE</del>     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>AT HOME</i> |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <i>Maryland</i> 13b. COUNTY <del>Baltimore</del> 13c. CITY OR TOWN <i>Baltimore</i> |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |
| 14. FATHER'S NAME<br>FIRST <i>NATHAN</i> MIDDLE <i>—</i> LAST <i>SLAVSKY</i>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <i>REBECCA</i> MIDDLE <i>—</i> LAST <i>POLSKY</i>             |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <i>NO</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>217 24 7076</i>  |   | 17. INFORMANT <i>M.R. SHELDON</i> ADDRESS <i>LOZINSKY</i><br><i>3006 BRENDAN AVE. #21213</i> |   |

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><i>immediate</i> |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Ruptured Aortic Aneurysm</i>  |  |   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>—</i>   |  |   |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.  
*hypertension, atherosclerotic cardiovascular disease*

|   |  |  |   |
|---|--|--|---|
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                           | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>—</i> P.M. <i>19</i> | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)     | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11/16</i> 19 <i>84</i> , to <i>11/16</i> 19 <i>84</i> , that (I) (we) lost<br>saw the deceased alive on above (I) (we) did (did not) view the body after death. |  |  |   |
| 22b. SIGNATURE<br><i>Bruce S. Gillies</i>   |  | DEGREE<br><i>MD</i>  | 22c. DATE SIGNED<br><i>11/16/84</i>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>BRUCE S. GILLIES</i>  |  | 22e. ADDRESS<br><i>SINAI HOSPITAL</i>  |   |

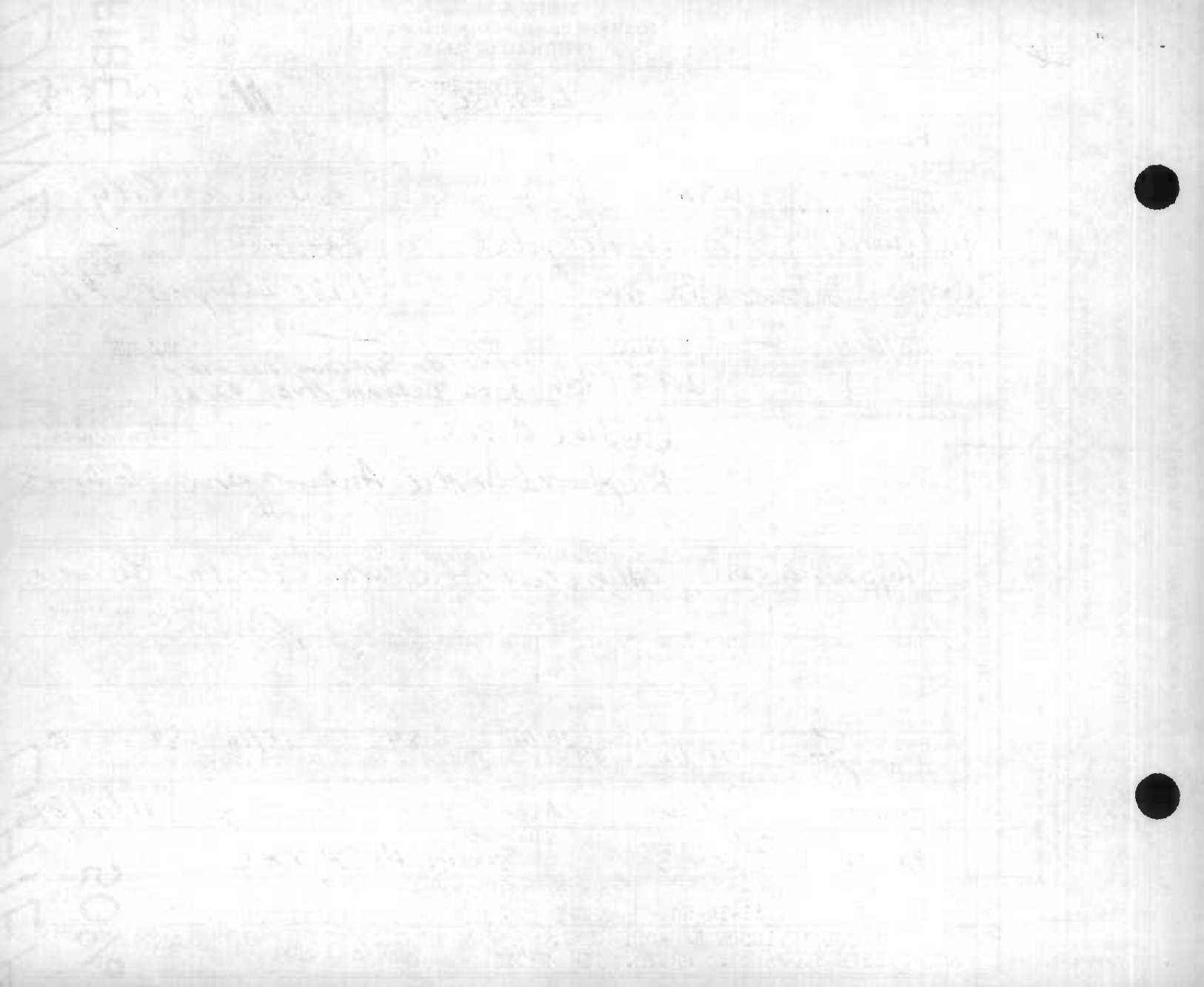
|   |                              |  |   |
|---|------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <i>BURIAL</i>  | 23b. DATE<br><i>11-18-84</i> | 23c. NAME OF CEMETERY OR CREMATORY<br><i>ANSHE EMUNAH</i>                                    | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>BALTIMORE MD</i> |
| 24. FUNERAL DIRECTOR<br>NAME <i>SOL LEVINSON &amp; BROS., INC.</i> ADDRESS <i>6010 REISTERSTOWN RD., BALTO., MD 21215</i> |                              | 25a. DATE REC'D. BY REGISTRAR <i>NOV 20 1984</i> 25b. REGISTRAR'S SIGNATURE <i>W. WARDEN</i> |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |   |  | REG. NO. 84 30058                            |  |
|---|--|--|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>LAURA E. LOUKE |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>11-21-1984 |   |  | 2b. HOUR<br>7:25 PM                          |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>4 15 1917   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>67 YRS.   |  | 7. IF UNDER 1 YEAR MONTHS DAYS  |  | 8. IF UNDER 24 HRS. HOURS MIN.               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>West Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes Hospital |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Sales Person                |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Stewarts   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE<br>Maryland  |  | 13b. COUNTY<br>A.A.  |  | 13c. CITY OR TOWN<br>Linthicum   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>6431 St. Phillip Road 21090  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Ernest Barkley   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE<br>Unknown Unknown   |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  |  |  | 16b. SOCIAL SECURITY NO.<br>212-28-6102  |  | 17. INFORMANT<br>Linda Johnson   |  | ADDRESS<br>Same as 13e  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Superior Mesenteric Thrombosis & Gangrene<br>DUE TO, OR AS A CONSEQUENCE OF (b) Thromboembolism of axillary & femoral arteries.<br>DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes, CVA, peripheral vascular disease, Wormen disease.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Diabetes. |  |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION<br>11/21/84  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Gangrene mid gut & thrombosis of arteries.                               |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)   |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NO WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/21/84, 19 to 11/21, 1984, that (I) (we) lost the deceased alive on 11/21/84, 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>A. L. Namas   |  |  |  | DEGREE MD.<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  |  | 22c. DATE SIGNED<br>11/21/84  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Namas A. L.  |  |  |  | 22e. ADDRESS<br>St. Agnes Hospital   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>11/26/84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Mem Park  |  | 23d. LOCATION<br>Glen Burnie A.A. Md.  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>George J. Gonce 4001 Ritchie Hwy Balto Md   |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 27 1984   |  |   |  |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8430059

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>MARSHALL W. LUCAS SR.   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 22 84   |  | 2b. HOUR<br>11:47AM  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Black   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>JAN. 8 - 19   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>65 YRS.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>VAMC, Baltimore, Maryland 21218 |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Chauffeur  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>Freight Lines   |  | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.                            |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore   |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br>2015 Robt St. 21218  |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Amos R. Lucas   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Maggie Washington   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>W.W.2   |  | 17. INFORMANT<br>ADDRESS<br>Mrs. Meredith Lucas 2015 Robt St.   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost                  |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Lung Cancer</u>   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that <u>XX</u> (this hospital) attended the deceased from <u>NOVEMBER 22, 1984</u> to <u>NOVEMBER 22, 1984</u> , that <u>X</u> (we) last saw the deceased alive on <u>NOVEMBER 22, 1984</u> , and that in <u>XX</u> (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (do) (do not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>Michael Econs MD   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Michael Econs MD  |  |  |  | 22e. ADDRESS<br>VAMC, Baltimore, Maryland 21218   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>11-27-84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Mem. Pk.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Arbutus Md.  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Randolph J. Collick  |  |  |  | ADDRESS<br>2431 E. Oliver St.   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 28 1984   |  |
|  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

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*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "1/1/1", "X", and "1/1/1" are visible.]*

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

84 30060

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |   |  |  |  |  |   |   |                                     |  |  |
|---|--|--|---|---|--|--|--|--|---|---|-------------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Margaret F. Lumpkins</b>   |  |  | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>20</b> YEAR <b>84</b> |   |  | 2b. HOUR <b>2:05</b> MIN <b>A</b>  |  |  |   |   |                                     |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>  |   | 5. DATE OF BIRTH<br>MONTH <b>3</b> DAY <b>13</b> YEAR <b>31</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>53</b> YRS.                              |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>                                       |   | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b>  |                                     |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Ky.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.                 |  |  |   |   |                                     |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |                                     |  |  |
| 13a. STATE<br><b>Md.</b>  |  |  |   |   |  | 13b. COUNTY<br><b>Balto.</b>   |  | 13c. CITY OR TOWN<br><b>Balto.</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |                                     | 13e. STREET ADDRESS / ZIP CODE<br><b>153 Palormo Ave 21229</b> |  |
| 14. FATHER'S NAME<br>(FIRST MIDDLE LAST)<br><b>William I. Robinson</b>  |  |  |   |   |  | 15. MOTHER'S MAIDEN NAME<br>(FIRST MIDDLE LAST)<br><b>Verda Porter</b>         |  |  |   |   |                                     |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |  |   | 16b. SOCIAL SECURITY NO.<br><b>406-44-2909</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Linda Beal 6760 Ransone Dr. 21207</b>           |  |  |   |   |                                     |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio Respiratory Arrest.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Pulmonary Edema/Cardiogenic Shock.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Coronary Artery Disease/I D D M.</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b> |  |  |   |   |  |  |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |                                     |  |  |
| 19a. DATE OF OPERATION  |  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                     |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |   |   |                                     |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  |   | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE, FARM ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |   |   |                                     |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 19</b> 19 <b>84</b> to <b>Nov 20</b> 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>Nov 20</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (add) (did not) view the body after death.  |  |  |   |   |  |  |  |  |   |   |                                     |  |  |
| 22b. SIGNATURE<br><b>Joseph F. Bonelli</b>  |  |  |   |   |  | DEGREE<br><b>MD</b>  |  |  | ATTENDING<br>PHYSICIAN <input type="checkbox"/> MEDICAL<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>11/20/84</b> |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Joseph Bonelli</b>  |  |  |   |   |  | 22e. ADDRESS<br><b>St. Agnes Hospital.</b>                                     |  |  |   |   |                                     |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  |   | 23b. DATE<br><b>11-23-84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Balto. National</b>                   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>                      |   |   |                                     |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H 1101 E. North Ave.</b>  |  |  |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 21 1984</b>                            |  | 25b. REGISTRAR'S SIGNATURE<br><b>William C. March</b>                                |   |   |                                     |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Items 18-22a 1/8/85 mtf F#599

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 30061

|  |  |   |  |   |   |   |  |   |   |  |
|--|--|---|--|---|---|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Deborah C. Lyles  |  |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>11/17/ 1984 |   |   | 2b. HOUR<br>M<br>10:29<br>A M   |  |   |   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11-6-1951   |   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>33 YRS.                                       |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.                         |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Smith, Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                         |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2746 Riggs Ave. |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Chef's Ass. - Inst |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |   |  |
| 13a. STATE<br>Md.  |  |   | 13b. COUNTY<br>Smith, C. City  |   | 13c. CITY OR TOWN<br>2746 Riggs Ave                     |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Freddie Lyles  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elizabeth Lyles                                       |   |   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No          |  |   | 17. INFORMANT<br>ADDRESS<br>2746 Riggs Ave  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Fatty Liver</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |  |   |  |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |   |  |   |   |   |  |   |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   |   |  |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)       |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                   |  |   |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |   |  |   |   |   |  |   |   |  |
| ACTUAL SIGNATURE <u>Margaret De Lyle</u>   |  |   |  |   |   | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER                                  |  | DATE SIGNED 11/18/84  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Margarita A. Korell, M.D.  |  |   | ADDRESS 111 Penn St.   |   |   |   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL  |  |   | 23b. DATE<br>11/21/84  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Zion Cemetery |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Smith, Md. County Md. |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>1712 W. North Ave  |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 19 1984  |  | 25b. REGISTRAR'S SIGNATURE<br>P. A. Davidson                        |   |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

20% COTTON FIBER

CHIEFLY IN BOND



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 8 4 3 0 0 6 2

1- FOR  
STATE  
REGISTRAR

|  |  |   |   |   |   |   |  |   |  |
|--|--|---|---|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Joseph J. Lynch SR. |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>18 20 84               |   |   | 2b. HOUR<br>7 <sup>46</sup> p.m.  |  |   |  |
| 3. SEX<br>male   |  | 4. RACE<br>Caucasian  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 14 25   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>59 YRS.  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Baltimore     |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Mercy Hospital |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Security Officer Hosp.                    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Union Mem.   |  |
| 13a. STATE<br>Maryland                                     |  |   | 13b. CITY OR TOWN<br>Baltimore                                |   | 13c. STREET ADDRESS<br>3506 Lyndale Ave |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Edward Lynch     |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Hannah Kelly |   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>Yes WW II |  |   |  |
| 16b. SOCIAL SECURITY NO.<br>218-18-0989                    |  |   | 17. INFORMANT<br>Anna Lynch, same address                     |   |   | 17. ADDRESS   |  |   |  |

|  |  |   |  |
|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>cardiac failure</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>myocardial infarction</u> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>none</u>  |  |   |  |

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION<br><u>none</u>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 2</u> , 19 <u>84</u> , to <u>Nov 20</u> , 19 <u>84</u> , that (I) (we) lost<br>saw the deceased alive on <u>Nov 20</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><u>Kathleen M. Fanning MD</u>   |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><u>11/20/84</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Kathleen M. Fanning, MD</u>   |  | 22e. ADDRESS<br><u>301 St. Paul Place Baltimore MD</u>                 |  |  |  |   |  |

|   |  |                       |  |   |  |   |  |
|---|--|-----------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial        |  | 23b. DATE<br>11/24/84 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holly Hill Cemetery Balto., Md. |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                  |  |
| 24. FUNERAL HOME, INC.<br>3331 Brehms Lane, Balto., Md. 21213 |  |                       |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 21 1984                          |  | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Randall</u> |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the health officer with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 4 3 0 0 6 3  
REG. NO.

|   |  |                         |   |   |  |  |  |   |  |   |  |
|---|--|-------------------------|---|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WILLIAM GILBERT LYONS</b>  |  |                         | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>29</b> YEAR <b>1984</b>   |   |  | 2b. HOUR<br><b>7:30</b> <b>AM</b>  |  |   |  |   |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b> |   | 5. DATE OF BIRTH<br>MONTH <b>8</b> DAY <b>21</b> YEAR <b>1917</b> |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> |  | 8. IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b> |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTIMORE</b>  |  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  |                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST AGNES HOSPITAL</b> |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Glass Blower</b>  |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Triangle Sign Co.</b>  |   |  |
| 13a. STATE<br><b>Maryland</b>   |  |                         | 13b. CITY OR TOWN<br><b>Baltimore</b>   |   |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   | 13d. STREET ADDRESS / ZIP CODE<br><b>1037 Maiden Choice Lane 21229</b>   |   |  |
| 14. FATHER'S NAME<br>FIRST <b>Samuel</b> MIDDLE <b>Samuel</b> LAST <b>Lyons</b>   |  |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Jessie</b> MIDDLE <b>Jessie</b> LAST <b>Hawk</b>   |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>YES</b>  |  |   | 16b. SOCIAL SECURITY NO.<br><b>WW II 212-07-1151</b>   |   |  |
| 17. INFORMANT<br><b>Hazel V. Shanahan</b>   |  |                         | ADDRESS<br><b>2825 Eastshire Dr. 21230</b>  |   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cordian arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Setpoint need by CA</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Adverse CA while with medical staff</b> |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |                         |   |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>  |  |                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/14</b> 19 <b>84</b> to <b>11/29</b> 19 <b>84</b> that (I) (we) last saw the deceased alive on <b>11/29</b> 19 <b>84</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                         |   |   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Accepted</b>   |  |                         | DEGREE  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |  |   | 22c. DATE SIGNED   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Accepted</b>  |  |                         | 22e. ADDRESS<br><b>Saint Agnes Hospital</b>   |   |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |  |                         | 23b. DATE<br><b>11/30/84</b>  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Security Process Co.</b>  |  |   | 23d. LOCATION<br>CITY OR TOWN <b>Catonsville</b> COUNTY <b>Baltimore</b> STATE <b>Md.</b>                                  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Hubbard Funeral Home, Inc.</b> ADDRESS <b>4107 Wilkens Ave.</b>   |  |                         | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 30 1984</b>   |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson</b>  |  |   |  |   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

84 30064

FOR  
1- STATE  
REGISTRAR

REG. NO.

|  |  |   |  |  |   |
|--|--|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>DORAH L LYTTLE</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 07 84</b>                         |  | 2b. HOUR<br><b>7:25 PM</b>  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>Black</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 10 17</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.                              | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore Md.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.              |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br><b>Md.</b>   |  |   | 13b. COUNTY  | 13c. CITY OR TOWN<br><b>Balto.</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert Lee Lyttle</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Agnes</b>                  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>214-14-8367</b>  | 17. INFORMANT ADDRESS<br><b>Julia Hanley 2223 E. Chase St</b>                  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>HYPOTENSION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>SEPSIS</b>   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>at death</b><br><b>2 hours</b><br><b>3 days</b>                                    |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.<br><b>cadexia, previous cardiac arrest &amp; hypotension</b>  |  |   |  |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> NO! WHERE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/5/84</b> to <b>11/7/84</b> , that (I) (we) lost<br>saw the deceased alive on <b>11/7/84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) did (did not) view the body after death. |  |   |  |  |   |
| 22b. SIGNATURE<br><b>Kenneth J. Holroyd</b>  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>11-7-84</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KENNETH J. HOLROYD</b>   |  | ADDRESS<br><b>JOHNS HOPKINS HOSPITAL<br/>600 N. Wolfe St. Baltimore MD 21205</b>  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11-13-84</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cem.</b>                    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md</b>   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Ave.</b>   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 9 1984</b>                             |  |   |
|  |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Rendall</b>                    |  |   |

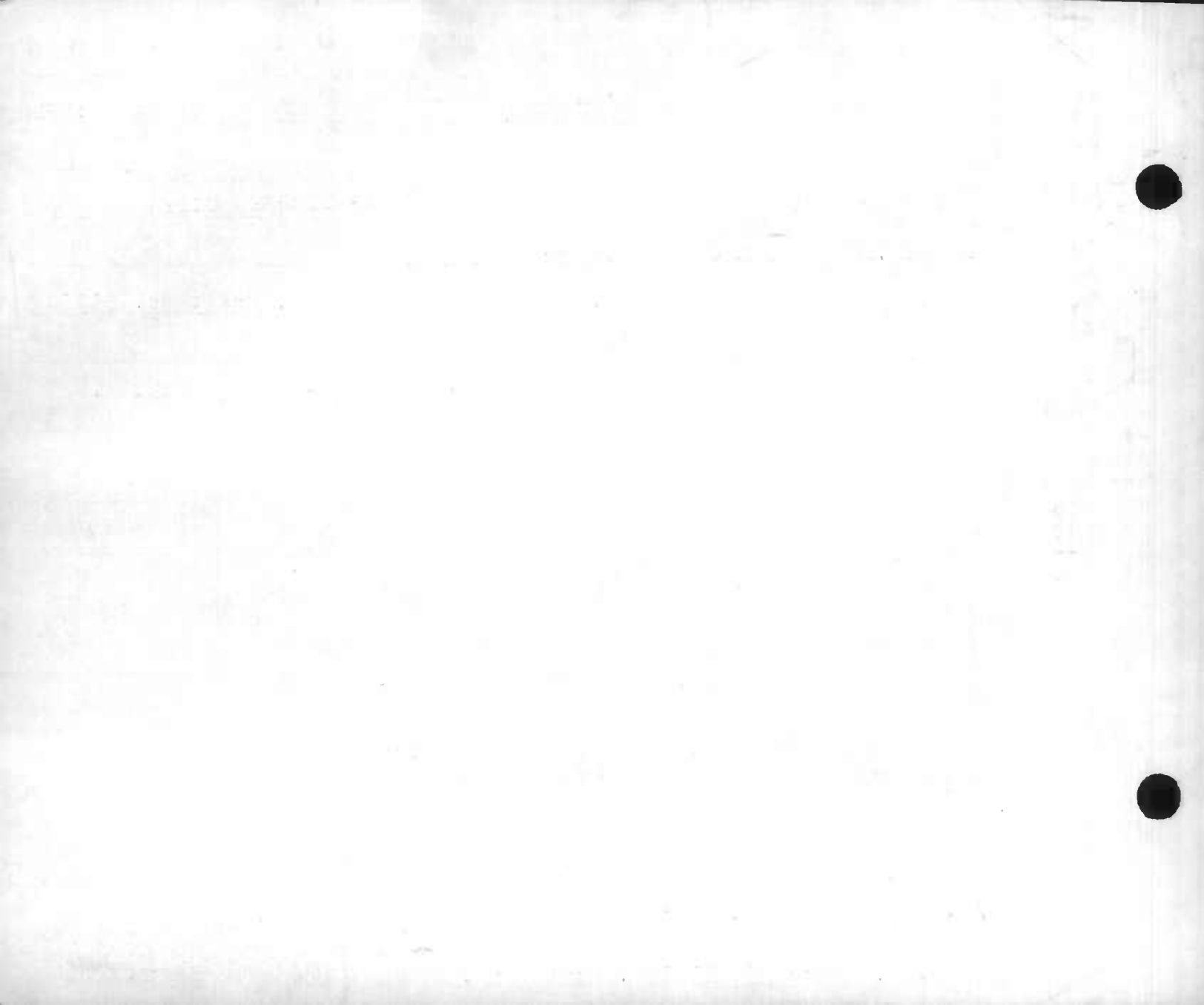
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, Page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

84 30065  
REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |   |   |  |
|--|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ETHEL M. MABRY</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11-14-84</b>                               |   | 2b. HOUR<br>M                                    |
| 3. SEX<br><b>F</b>   | 4. RACE<br><b>W</b>  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>8-22-1904</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>COLORADO</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY - MD.</b>                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3201 CLEARVIEW AVE.</b> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOMEMAKER</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>HOME</b> |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD.</b> |  | 13b. COUNTY<br><b>—</b>   | 13c. CITY OR TOWN<br><b>BALTO.</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>ADRAIN ANAHEIM</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>FLORA BELLE WRIGHT</b>   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>232-38-0907</b>  |   | 17. INFORMANT ADDRESS<br><b>Mrs. Zuchie Dolina - 3201 Clearview Ave. 21234</b>                  |  |

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   | DUE TO, OR AS A CONSEQUENCE OF (b) <b>MYOCARDIAL INFARCTION</b>   |  |
|  | DUE TO, OR AS A CONSEQUENCE OF (c) <b>CORONARY ARTERY DISEASE</b> |  |
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| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |   |  |  |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                       |  |
| 22a. I certify that (this hospital) attended the deceased from <b>11/30</b> , 19 <b>84</b> , to <b>11/14</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>6/4</b> , 19 <b>84</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |   |  |  |
| 22b. SIGNATURE<br><i>Miguel Karacusechansky</i>   | DEGREE<br><b>M.D.</b>   | 22c. DATE SIGNED<br><b>11/15/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MIGUEL KARACUSECHANSKY</b>  | 22e. ADDRESS<br><b>300 E. 33rd ST BALTO MD 21218</b>                | 22f. ADDRESS   |  |

|  |                              |   |  |
|--|------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>     | 23b. DATE<br><b>11-17-84</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PARKWOOD CEM</b>   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTO, MD.</b> |
| 24. FUNERAL DIRECTOR<br><i>Heath Miller - 7527 Hanford Rd.</i> |                              | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 16 1984</b>         |  |
|  |                              | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i> |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, and 3 should be filed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified also.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |   |  |  |   |  |  | 8 4 3 0 0 6 6                                |  |
|--|--|--|---|---|--|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  | REG. NO.  |   |  |  |   |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  | FIRST MIDDLE LAST<br>ALICE M. MACE                                  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>11 / 10 / 84   |   |  | 2b. HOUR<br>2:42 A.M.                        |  |  |
| 3. SEX<br>F  |  | 4. RACE<br>W   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>10 21 06   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS.   |   | IF UNDER 1 YEAR MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN.                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Annapolis, Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balt. City MD.   |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore City  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>North Charles General Hosp |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE md  |  |  | 13b. COUNTY Balt  |   | 13c. CITY OR TOWN<br>Baltimore                         |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>7899 Rolling View Ave |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Absalon Anderson  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Ruby Ward             |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no   |   |  |  |  |  |
| 16b. SOCIAL SECURITY NO.<br>215566749  |  |  | 17. INFORMANT<br>Dorothy Laudenklos                                 |   |  | ADDRESS 4115 Lincoln Ave. Balto., Md. 21236  |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) SEPTICEMIA & SHOCK<br>DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE RENAL FAILURE<br>DUE TO, OR AS A CONSEQUENCE OF (c) ACUTE PULMONARY EDEMA<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: HYPERCALCEMIA |  |  |   |   |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/10/84 to 10/30/84, that (I) (we) last saw the deceased alive on 11/10/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.   |  |  |   |   |  |  |   |  |  | 22c. DATE SIGNED<br>11/10/84                 |  |
| 22b. SIGNATURE<br>A.C. Chowvalit, M.D.   |  |  | DEGREE  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>A.C. CHOUVALIT, M.D.  |  |  | 22e. ADDRESS<br>NORTH CHARLES GEN. HOSP.                            |   |  |  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |  | 23b. DATE<br>11-13-84   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens of Faith |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore, Md.                                       |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Lassahn Funeral Home  |  |  | 4401 Belair Rd. BALTO. MD. 21236                                    |   | 25a. DATE REC'D. BY REGISTRAR                          |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 3 0 0 6 7

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |   |  |   |  |  |
|---|--|--|--|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>CHARLES G. MACK</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 11 84</b>                 |   |   | 2b. HOUR<br><b>7<sup>36</sup> P.M.</b>   |   |  |  |
| 3 SEX<br><b>MALE</b>  |  | 4 RACE<br><b>NEGRO</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 17 25</b>  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b> YRS.                                     |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE</b> MD.                          |   |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MD</b>   |  |  | 13b. COUNTY<br><b>BALTIMORE</b>  |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                               |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Arthur Mack</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>France Curry</b>   |   |   | 13e. STREET ADDRESS / ZIP CODE<br><b>5107 Sunset Rd. 21215</b>                       |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  |  | 16b. SOCIAL SECURITY NO<br><b>219-18-8699</b>                          |   | 17 INFORMANT<br>ADDRESS<br><b>Emily Jones 5107 Sunset Rd. 21215</b> |  |   |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Hypocalcemia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Chronic Renal Failure</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                    |  |  |  |   |   |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>metastatic esophageal CA, Sepsis, Hypertension</b>  |  |  |  |   |   |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-11-84</b> , 19 <b>84</b> , to <b>11-11-84</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>11-11</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |  |   |  |  |
| 22b. SIGNATURE<br><b>Roberta K. Tabaka</b>  |  |  |  |   |   | DEGREE<br><b>DO</b>  |   | 22c. DATE SIGNED<br><b>11-11-84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Roberta K. TABAKA</b>   |  |  |  |   |   | 22e. ADDRESS<br><b>9246 Red Cart Ct, Columbia, MD 21045</b>                          |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>11-16-84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Forest V.A.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Owings Mills Md.</b>                           |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H 1101 E. North Ave.</b>  |  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 13 1984</b>                                  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Lelia Davidson-Randell</b>  |  |

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |  |  |  |   |  |  |
|---|---|---|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |   |   | 2a. DATE OF DEATH  |  |  | 2b. HOUR  |  |  |
| JAMES RUSSELL MACK, Jr.   |   |   | 11/18/1984   |  |  | 10.35 AM  |  |  |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |  | 7. IF UNDER 1 YEAR  |  |  |
| MALE  | BLACK   | 2 17 1934   | 50 YRS.  |  |  | MONTHS DAYS HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |   |  |  |
| Maryland  | U. S. A.  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |  |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)       |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| Baltimore   | North Charles General Hospital  |   | Mechanic   |  |  | Gas & Electric  |  |  |
| 13a. STATE  |   |   | 13b. COUNTY  |  |  | 13c. CITY OR TOWN   |  |  |
| Maryland  |   |   |  |  |  | Baltimore   |  |  |
| 14. FATHER'S NAME   |   |   | 15. MOTHER'S MAIDEN NAME   |  |  | 16. SOCIAL SECURITY NO.   |  |  |
| James R. Mack Sr.   |   |   | Ella V. Hawkins  |  |  | 219-30-4381   |  |  |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |   |   | 17b. SOCIAL SECURITY NO.   |  |  | 17. INFORMANT   |  |  |
| Yes   |   |   | 2-56 -12-57  |  |  | Virginia M. Mack  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) METASTATIC COLON CANCER<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                           |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |   |   |  |  |  |   |  |  |
| 19a. DATE OF OPERATION  |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a. AUTOPSY?   |  |  |
| —   |   |   | —  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                      |  |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death.   |   |   | 22b. SIGNATURE<br>AN JARIA M.D.  |  |  | 22c. DATE SIGNED<br>11/18/84  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |   |   | 22e. ADDRESS   |  |  | 22f. DATE REC'D. BY REGISTRAR   |  |  |
| AN JARIA M.D.   |   |   | North Charles Hospital<br>Baltimore MD 21218                           |  |  | NOV 21 1984   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |   |   | 23b. DATE  |  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |  |
| Burial  |   |   | 11/23/1984   |  |  | Garrison Forest Veterans Owings Mills, Maryland                               |  |  |
| 24. FUNERAL DIRECTOR<br>NAME  |   |   | 25. DATE REC'D. BY REGISTRAR   |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |
| Nutter & Sons<br>Funeral Home Inc. Baltimore, Maryland 21216  |   |   | NOV 21 1984  |  |  | Gina Davidson-Hendall   |  |  |

NAME: JAMES S. RUSSELL  
 RACE: BLACK  
 BIRTH: 11/16/1924  
 BIRTHPLACE: Baltimore City  
 RESIDENCE: 3203 Roslyn Avenue, Baltimore, Maryland  
 EMPLOYER: North Charles General Hospital  
 OCCUPATION: Electrician  
 STATUS: V. (Veteran)  
 SERVICE: 12-25-42 to 12-25-45  
 BRANCH: Army  
 GRADE: Staff Sergeant  
 DISCHARGE: 12-25-45  
 REASON: Completion of tour of duty  
 CHARACTER OF SERVICE: Satisfactory

11/23/1994 Garrison Forest Veterans Center, Baltimore, Maryland  
 3501 Gwynns Falls Parkway  
 General Home Inc. Baltimore, Maryland 21216  
 Water & Sons  
 11/23/1994

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>HAYWOOD G MADISON Jr.   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 / 3 / 1984 |   |  | 2b. HOUR<br>6:45 PM  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 02 1954   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>30 YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNIVERSITY OF MARYLAND |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Machinist   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Donn Corp.  |  |
| 13a. STATE<br>MARYLAND   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>HAYWOOD G. MADISON Sr.   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>HARRIETT HAWKINS   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No.   |  |  |  |
| 16b. SOCIAL SECURITY NO.<br>213-64-5104  |  | 17. INFORMANT<br>Harriett Madison   |  | 2930 Windsor Avenue<br>Baltimore, Maryland 21216  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) Cardio pulmonary arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Pneumocystis carinii pneumonia<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) AIDS (Acquired immunodeficiency syndrome)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>45 min |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NO WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/28/84 to 11/3/84, that (I) (we) last saw the deceased alive on 11/3/84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>T. Nguyen MD   |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br>11/3/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>THUY VI NGUYEN  |  | 22e. ADDRESS<br>UNIVERSITY OF MARYLAND HOSP   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>11/09/1984   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Zion Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland  |  |
| 24. FUNERAL DIRECTOR<br>(NAME)<br>Funeral Home Inc.  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 7 1984   |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |  |  |  |
| 25c. ADDRESS<br>2501 Gwynns Falls Parkway<br>Baltimore, Maryland 21216   |  |   |  |   |  |  |  |



17/08/1964 17.10.1964  
Letter A 3086  
2501 Avenue 1110 Highway  
Invernal Home Inc. Balaclava, New South Wales

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| 1. FOR STATE REGISTRAR  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  | REG. NO. 30070   |  |
|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)  |  | 2b. DATE OF DEATH  |  | 26. HOUR   |  |
| FIRST MIDDLE LAST<br>LUTHER MARSHALL  |  | MONTH DAY YEAR<br>11 4 84  |  | 5 45 AM  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  |
| M   |  | B  |  | MONTH DAY YEAR<br>11 - 13 - 1932   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. AGE (IN YEARS LAST BIRTHDAY)  |  |
| Maryland  |  | U.S.A.   |  | 51 YRS.  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                     |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |
| Baltimore   |  | University of Maryland Hospital  |  | Baltimore MD.  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| Bethleam Stell  |  |  |  |  |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  |
| Maryland  |  |  |  |  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |
| FIRST MIDDLE LAST<br>Luther Marshall  |  | FIRST MIDDLE LAST<br>Mildred Haywood   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |
| yes   |  | Korean War   |  | Elaine Blake 1109 Longwood St. 21216   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| PART 1. DEATH WAS CAUSED BY:  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) HYPOTENSION, COAGULOPATHY   |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |  |  |
| (b) SEPSIS OF UNKNOWN ORIGIN  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |
| (c)   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  |
| 11/3/84   |  | INTESTINAL DISTENTION  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
|   |  | P.M. 19  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |
|   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 9 AM 11/3, 19 84, to 5 45 PM 11/4, 19 84, that (I) (we) lost saw the deceased alive on 11/4, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE  |  | DEGREE   |  | 22c. DATE SIGNED   |  |
| CARL P VALENZIANO MD  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 11/4/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |  |
| CARL P VALENZIANO   |  | M I EMSS   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| Burial  |  | 11-9-84  |  | Garrison Forest Cem.   |  |
| 24. FUNERAL DIRECTOR NAME   |  | 24b. ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR  |  |
| Vernon R. Bailey  |  | 1348 N. Calhoun Street   |  | NOV 7 1984   |  |
|   |  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |
|   |  |  |  | Wanda Davidson-Gondell   |  |





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## MEDICAL CERTIFICATION

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 3 0 0 7 1

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |  |  |   |   |  |  |  |  |
|---|--|--|--|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>BEULAH A. MARTIN</b>   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11/10/84</b>                    |   |   | 2b. HOUR<br><b>1033 PM</b>   |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>M <sup>th</sup> DAY YEAR<br><b>12 25 05</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto. Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Simon Hosp</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)<br><b>retired</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   |   |  |  |  |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>1600 Mt. Royal Ave. 21217</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unk.</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Blagmon</b> |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS<br><b>Joseph Martin, Jr. 1218 Valley St.</b>  |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiogenic Shock</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |  |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-8-84</b> to <b>11-10-84</b> , that (I) (we) last saw the deceased alive on <b>11-10-84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                      |  |  |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>E. Edwards Franco</b>  |  |  | DEGREE   |   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/10/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>E. Edwards Franco</b>   |  |  | 22e. ADDRESS<br><b>Simon Hosp of Balto.</b>                            |   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>11-16-84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Balto. Md.</b>         |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. MD</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Ave.</b>  |  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 13 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Davidson-Randall</b>   |  |

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CHIEF XMAS

20% COTTON F



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 4 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, medical attention should be noted at the time of death.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 4 3 0 0 7 2   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1 - FOR STATE REGISTRAR   |  |  |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>ZELMA P MARTIN</b>   |  |  |  | 7a. DATE OF DEATH MONTH DAY YEAR<br><b>11/2/84</b>  |  | 7b. HOUR<br><b>12 30 AM</b>   |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>BLACK</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>6 9 10</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS<br><b>74</b> YES  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIV.</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>COMPUTER LIBRARIAN</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>MD.</b>  |  |  |  | 13b. CITY OR TOWN<br><b>Hurlock</b>   |  | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>SAMUEL PROCTOR</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>VIOLA GEORGE</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO.</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>217-01-4398A</b>  |  | 17. INFORMANT ADDRESS<br><b>RT 2, BOX 39</b><br><b>WILLIAM P. MARTIN HURLOCK, MD. 21643</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>exsanguination</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>venous injury</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>20 minutes</b><br><b>8 hrs.</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Stage IV carcinoma of colon</b>   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>11/1/84</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Stage IV Ca Colon to Liver</b>                                  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/30</b> 19 <b>84</b> to <b>11/2</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>11/2</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) (did not) view the body after death.                              |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Marc B Applestein</b>  |  |  |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>11/2/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Marc B Applestein</b>   |  |  |  | 22e. ADDRESS<br><b>c/o UNIV. hosp.</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11/5/1984</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Memorial Park</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |  |
| 24. FUNERAL HOME OR OTHER INSTITUTION NAME ADDRESS<br><b>Nutter &amp; Sons 2501 Gwynns Falls Parkway</b><br><b>Funeral Home Inc. Baltimore, Maryland 21216</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 7 1984</b>  |  |   |  |
|   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |   |  |

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Felis Leome Inc. Baltimore, Maryland 21216  
11/2/58  
Mr. & Mrs. Leome  
2501 Gwynn Falls Parkway  
Baltimore, Maryland 21216

Mr. & Mrs. Leome  
2501 Gwynn Falls Parkway  
Baltimore, Maryland 21216

11/1/58  
Mr. & Mrs. Leome  
2501 Gwynn Falls Parkway  
Baltimore, Maryland 21216

Mr. & Mrs. Leome  
2501 Gwynn Falls Parkway  
Baltimore, Maryland 21216

Mr. & Mrs. Leome  
2501 Gwynn Falls Parkway  
Baltimore, Maryland 21216

BP \_\_\_\_\_  
 DHMH - 16 50M 1/81  
 (VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  |  |  |                                    |  |  | 8 4 3 0 0 7 3                                 |  |
|---|--|--|--|--|--|--|------------------------------------|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  | CERTIFICATE OF DEATH   |  |                                    |  |  | REG. NO.                                      |  |
| 1 DECEASED NAME (TYPE OR PRINT)<br><b>FREDERICK</b>   |  |  |  |  | 2a DATE OF DEATH<br>MONTH <b>11</b> DAY <b>25</b> YEAR <b>84</b>                     |  |                                    |  |  | 2b HOUR<br><b>M</b>                           |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>4</b> DAY <b>10</b> YEAR <b>19</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS.   |                                    | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>   |  | IF UNDER 24 HRS<br>HOURS <b></b> MIN. <b></b> |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.   |                                    |  |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Balto.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2508 N. Charles St.</b> |  |  |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Painter</b>   |                                    | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Self-employed</b>  |  |   |  |
| 13a. STATE<br><b>Md.</b>  |  |  |  |  | 13b. COUNTY<br><b>--</b>   |  | 13c. CITY OR TOWN<br><b>Balto.</b> |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 14 FATHER'S NAME<br>FIRST <b>Frederick</b> MIDDLE <b></b> LAST <b>Marx</b>  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Catherine</b> MIDDLE <b></b> LAST <b>Donoho</b> |  |                                    |  |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b SOCIAL SECURITY NO.<br><b>WWII</b>   |  | 17 INFORMANT<br><b>Ms. Virginia Buskirk</b>  |  | ADDRESS <b>3022 N. Calvert St. Balto., Md.</b>   |                                    |  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b>  |  |  |  |  |  |  |                                    |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ASCVD</b>  |  |  |  |  |  |  |                                    |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>   |  |  |  |  |  |  |                                    |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Chronic Obstructive Pulmonary Disease</b>  |  |  |  |  |  |  |                                    |  |  |   |  |
| 19a DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                    | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |                                    |  |  |   |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |                                    |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July</b> 19 <b>84</b> to <b>October</b> 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>October 18</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (If we did not view the body after death). |  |  |  |  |  |  |                                    |  |  |   |  |
| 22b. SIGNATURE<br><b>Angela L. Corbin, MD</b>   |  |  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                    | 22c. DATE SIGNED<br><b>11/30/84</b>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ANGELA L. CORBIN, MD.</b>   |  |  |  | 22e ADDRESS<br><b>LOCH RAVEN V.A. HOSP. BALTO., MD.</b>  |  |  |                                    |  |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Removal</b>  |  | 23b. DATE<br><b>11/25/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |                                    | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Anatomy Board</b>   |  |  |  | ADDRESS<br><b>Balto., Md</b>   |  |  |                                    |  |  |   |  |

DEC 07 1984  
 J. A. Davidson, Registrar



CONSTRUCTION PROJECT

REPORT

CONSTRUCTION PROJECT

DATE: 10/10/10

BY: [Signature]

FOR: [Signature]

PROJECT: [Signature]

10/10/10

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 3 0 0 7 4

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Edna Massey</i>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>11/29/84</i> |   | 2b. HOUR<br><i>6:50 A.M.</i>   |   |  |
| 3. SEX<br><i>F</i>   |  | 4. RACE<br><i>B</i>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>2 1 10</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><i>74</i>                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>S.C.</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Balt. none City</i>                                  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Balt.</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Lutheran Hosp.</i> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  |
| 13a. STATE<br><i>Md.</i>   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><i>Balt.</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Louis Stroud</i>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Amanda Massey</i>  |  | 13e. STREET ADDRESS<br><i>201 N. Broadway</i>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>NO</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>240-466268</i>  |  | 17. INFORMANT ADDRESS<br><i>Louise McLaughlin 201 N. Broadway</i>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardi-pulmonary Arrest</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>sepsis</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11/29, 1984</i> to <i>11/29, 1984</i> , that (I) (we) last saw the deceased alive on <i>19</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                  |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><i>M. J. H., MD</i>  |  |  |  | DEGREE<br><i>MD</i>   |  | 22c. DATE SIGNED<br><i>11/29/84</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Henry Ohlgen</i>   |  |  |  | 22e. ADDRESS<br><i>Lutheran Hospital</i>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>12/4/84</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Baltimore Cem.</i>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore MD</i>                               |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Wm. C. March F/H 1101 E. North Ave.</i>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>DEC 4 1984</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>                                     |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

BP

RECEIVED



CHILLMAN



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate is completed and signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |   |   |  | 8 4 3 0 0 7 5  |   |
|---|---|---|--|--|---|
| FOR<br>1 - STATE REGISTRAR  |   |   |  | REG. NO.   |   |
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>JENNIE E MATTHEWS   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>NOVEMBER 23, 1984         |  | 2b. HOUR<br>9:58 a.m.   |
| 3 SEX<br>Female   | 4. RACE<br>Black  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 17 10   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                       |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>VA  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                           |   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>JOHNS HOPKINS HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY                               |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD   |   |   | 13b. COUNTY<br>Baltimore   | 13c. STREET ADDRESS / ZIP CODE<br>2131 E. Federal St. 21213                          |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Clarence Harris   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ida Green  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |   | 16b. SOCIAL SECURITY NO.<br>218-30-5687   |  | 17. INFORMANT<br>ADDRESS<br>Robert Matthews 4118 Brendan Ave.                        |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Intracerebral bleed</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5 min<br>3 days |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>Hypertension</u>   |   |   |  |  |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)       |  |  |   |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>NOV 20</u> , 19 <u>84</u> , to <u>NOV 23</u> , 19 <u>84</u> , that (I) <input checked="" type="radio"/> saw the deceased alive on <u>NOV 23</u> , 19 <u>84</u> , and that in (my) <input checked="" type="radio"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="radio"/> did not view the body after death. |   |   |  |  |   |
| 22b. SIGNATURE<br><u>Daniel Ford</u>  |   | DEGREE<br>M.D.  |  | 22c. DATE SIGNED<br>11/23/84   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DANIEL FORD M.D.   |   | 22e. ADDRESS<br>JOHNS HOPKINS HOSPITAL BALTIMORE MD   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |   | 23b. DATE<br>11/28/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Md. Nat'l Mem. Pk.                             |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Laurel MD   |   | 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H 1101 E. North Ave.   |  |  |   |
| 25a. DATE REC'D. BY REGISTRAR<br>NOV 26 1984  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson Fendell</u>   |  |  |   |

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Handwritten text at the bottom of the page, possibly a signature or date.

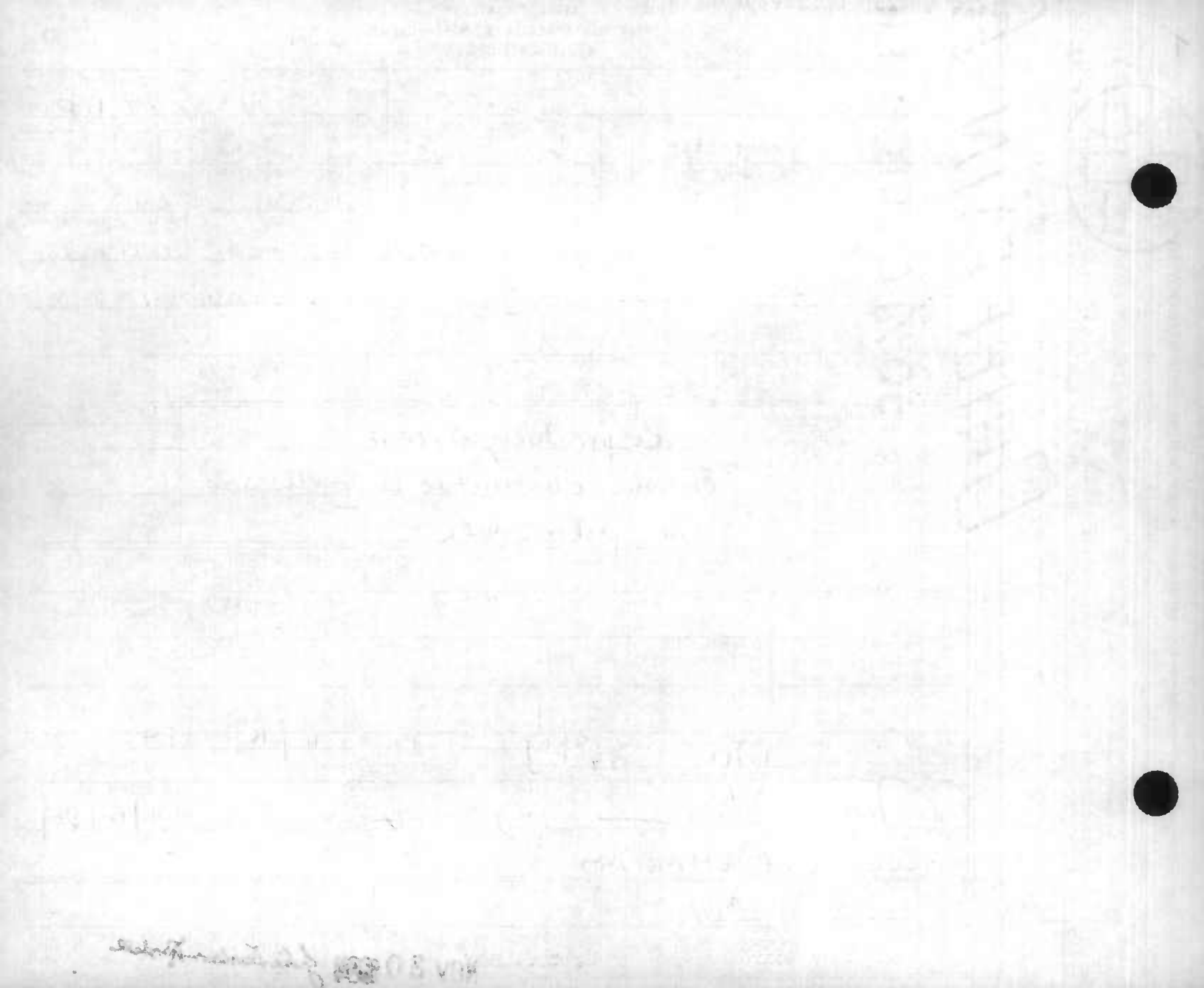
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |   |  |  |  |  | 84 30076                                     |  |
|--|--|--|--|---|---|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   |   |  |  |  |  | REG. NO.                                     |  |
| 1 DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><u>Gladys</u> <u>Maynard</u>   |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><u>11</u> <u>16</u> <u>84</u> |  |  | 2b. HOUR MIN.<br><u>11</u> <u>10</u> P. M.   |  |  |  |
| 3 SEX<br><u>FEMALE</u>   |  | 4 RACE<br><u>caucasian</u>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><u>8</u> <u>13</u> <u>15</u>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>69</u> YRS                                     |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Maryland</u>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><u>Baltimore</u> <u>City</u> MD.              |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><u>Baltimore</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Lafayette Square Nursing Center</u> |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>UNKNOWN</u>      |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>UNKNOWN</u>  |  |  |  |
| 13a. STATE<br><u>Md.</u>   |  | 13b. COUNTY<br><u>--</u>   |  | 13c. CITY OR TOWN<br><u>Balto.</u>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><u>501 W. Franklin Ave.</u> <u>21201</u>  |  |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |   |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)<br><u>Unkn.</u>   |  | 16b. SOCIAL SECURITY NO.<br><u>962-13-2578</u>   |  | 17 INFORMANT ADDRESS  |   |  |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.<br>(b) <u>Chronic obstructive Lung disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Cor pulmonale</u> |  |  |  |   |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |  |  |   |   |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><u>P.M.</u> <u>19</u>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21i. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/9</u> , 19 <u>79</u> , to <u>11/16</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>11/17</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |   |   |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Moges Gebremariam</u>   |  |  |  | DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  |  | 22c. DATE SIGNED<br><u>11/18/84</u>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>MOGES GEBREMARIAM</u>  |  |  |  | 22e. ADDRESS  |   |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Removal</u>  |  | 23b. DATE<br><u>11/17/84</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><u>Anatomy Board</u>  |  |  |  | ADDRESS<br><u>Balto., Md.</u>   |   | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson</u>  |  |  |  |

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NOV 30 1984



Part 2 - verified w/ M.E. Office 11/2/84 kam

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 3 0 0 7 7

FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>William</b><br><b>(WILLIAM)</b>  |  | MIDDLE<br><b>McCAFFITY</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOV 1 84</b>  |  | 2b. HOUR<br><b>1000 A</b>  |  |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>N</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>06 22 22</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NC</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MIEMSS, Univ. of Md.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. CITY OR TOWN<br><b>BALTIMORE</b>  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>821 MCKEAN AVE 21217</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HENRY McCAFFITY</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>BEATRICE HOPKINS</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR IF YES, GIVE WAR OR DATES)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>243-18-5525</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Effie Mc Caffity 821 McKean Ave 21217</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>UPPER G.I. BLEED</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ESOPHAGEAL VARICES</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>HEPATIC CIRRHOSIS</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>TRAUMA - PT. JUMPED FROM PORCH; CHR. PANCREATITIS</b>   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>10 29 1984</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br><b>PT. JUMPED FROM PORCH.</b>   |  |  |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>HOME</b>  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>821 MCKEAN AVE BALTIMORE MD</b>   |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from <b>10/29</b> 19 <b>84</b> , to <b>11/1/84</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>11/1</b> 19 <b>84</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) view the body after death.  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>M. Jutovich MD</b>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>11/1/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>M. Jutovich</b>   |  |  |  | 22e. ADDRESS<br><b>MIEMSS, 225. Greene St, Baltimore, Md.</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11-7-84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Forest V.A.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Owning Mills Md.</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H 1101 E. North Ave.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 2 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |

BP

NOV 1 1964

(WILLIAM) (M. CANTY)

NC U.S.A. X

BALTIMORE, MD

MD BALTIMORE, MD

HEPATITIS CIRCULUS

UPPER (A.T. BLEED)

ESOPHAGEAL ULCER

HEPATITIS CIRCULUS

TRAUMA - R. JAW - CHIN FRACTURES

NO 21 R. FR. JAW FROM BIRTH

HOME 321 WICKERMAN BLVD BALTIMORE MD

NO 21 R. FR. JAW FROM BIRTH

NO 21 R. FR. JAW FROM BIRTH

NO 21 R. FR. JAW FROM BIRTH

NO 21 R. FR. JAW FROM BIRTH



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 3 0 0 7 8

FOR  
1. STATE  
REGISTRAR

REG. NO.

|   |   |   |  |   |   |
|---|---|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>DAVID A. MCCOY   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 25 84                  |   | 2b. HOUR<br>10:46 AM  |
| 3. SEX<br>Male  | 4. RACE<br>Black  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 30 51   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>33 YRS                        | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD        |   |   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY   |   |
| 13a. STATE<br>MD  |   | 13b. COUNTY   | 13c. CITY OR TOWN<br>Baltimore                                   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Alvin McCoy   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elizabeth H. Johnson   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |   | 16b. SOCIAL SECURITY NO.<br>216-52-0261   | 17. INFORMANT ADDRESS<br>Elizabeth McCoy 1704 E. Preston St.     |   |   |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiovascular arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>intracerebral bleed</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>bacterial endocarditis</u><br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STOTING THE UNDERLYING CAUSE LAST. |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>0<br>7 hrs<br>2 weeks |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>Rheumatic heart disease</u>  |   |   |  |   |   |
| 19a. DATE OF OPERATION<br>11/25/84  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>intracerebral bleed   |  | 20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO               |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>11/10</u> 19 <u>84</u> to <u>11/25</u> 19 <u>84</u> , that (1) (we) last saw the deceased alive on <u>11/25</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.                                       |   |   |  |   |   |
| 22b. SIGNATURE<br><u>J. K. Harrison</u>   |   | DEGREE<br>MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>     |  | 22c. DATE SIGNED<br>11/25/84  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>J. K. Harrison   |   | 22e. ADDRESS<br>The Johns Hopkins Hospital  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |   | 23b. DATE<br>11/30/84   | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Mem. Pk.           |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co. MD        |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H  |   | 1101 E. North Ave.  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 28 1984  |   |
|   |   | 25b. REGISTRAR'S SIGNATURE<br><u>J. K. Harrison</u>   |  |   |   |



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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

8 4 3 0 0 7 9

1 - FOR  
STATE  
REGISTRAR

DONALD THOMAS McCRACKEN

REG. NO.

|  |  |   |  |  |   |
|--|--|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>DONALD THOMAS McCRACKEN  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 30 84                                      |  | 2b. HOUR<br>143 P.M.  |
| 3. SEX<br>MALE   | 4. RACE<br>WHITE   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct. 26, 1933   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>51 YRS.   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |  |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Ret. Bell of PA. |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Telephone  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE COUNTY<br>Delaware Sussex   |  |   | 13b. CITY OR TOWN<br>Millsboro   | 13c. STREET ADDRESS / ZIP CODE<br>10 Kerlyn Drive 99999                              |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Raymond McCracken  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Grace Taylor   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, IF FOR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>149-26-5832   |  | 17. INFORMANT ADDRESS<br>Helen McCracken, Millsboro, Del.                            |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIOVASCULAR COLLAPSE</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>INTRA OPERATIVE HYPOTENSION</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>HYPOTENSION</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>MINUTES   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><u>CIRRHOSIS</u>   |  |   |  |  |   |
| 19a. DATE OF OPERATION<br>NOV 30, 1984   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>PORTAL HYPERTENSION   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)        |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY, OFFICE FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>NOV 28</u> , 19 <u>84</u> , to <u>NOV 30</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>NOV 30</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (which) (which) view the body after death.                           |  |   |  |  |   |
| 22b. SIGNATURE<br><u>Michael Rossini Jr MD</u>   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>11/30/84   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MICHAEL ROSSINI JR MD   |  | 22e. ADDRESS<br>22 So. Greene Balto MD 21201  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   | 23b. DATE<br>12/4/84   | 23c. NAME OF CEMETERY OR CREMATORY<br>Millsboro Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Millsboro, Sussex, Delaware            |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>George J. Gonce, 4001 Ritchie Hg., Baltimore, MD 21225   |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 3 1984   |  |  |   |
|  |  | 25b. REGISTRAR'S SIGNATURE<br><u>one warder - H. G. Gonce</u>   |  |  |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 4 3 0 0 8 0   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Ida McDaniel</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>November 14, 1984</b>   |  | 2b. HOUR <b>M</b>   |  |
| 3. SEX <b>Female</b>  |  | 4. RACE <b>Black</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>2 13 91</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>93</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Va.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH <b>Balto.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4801 The Alameda</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE <b>Md.</b>   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN <b>Balto.</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME (TYPE OR PRINT) <b>Harrison</b>   |  | 15. MOTHER'S MAIDEN NAME (TYPE OR PRINT) <b>Virginia</b>   |  | 13e. STREET ADDRESS <b>4801 The Alameda 21218 Ave. 21212</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO. <b>217-05-4138</b>  |  | 17. INFORMANT ADDRESS <b>Charles McDaniels 4500 Kenilworth</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>UREMIA</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>CHR. NEPHRITIS</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8-12, 19 55</b> , to <b>11-14, 19 84</b> , that (I) (we) last saw the deceased alive on <b>11-8, 19 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE <b>Jerome Gaber</b> DEGREE   |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED <b>11-16-84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JEROME GABER</b>   |  |  |  | 22e. ADDRESS <b>5706 Belknap Ave Balt Md 21212</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>11-17-84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem.</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arbutus Md Baltimore</b>   |  |
| 24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H</b> ADDRESS <b>1101 E. North Ave.</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>NOV 19 1984</b> 25b. REGISTRAR'S SIGNATURE   |  |   |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8430081

REG. NO.

FOR  
STATE  
REGISTRAR

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Gloria Ann McDonald   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 21, 1984  |  | 2b. HOUR<br>M  |
| 3. SEX<br>Female  | 4. RACE<br>Negro   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 1, 1954   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>30  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>New York  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD                                      |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>770 W. Saratoga St. Apt. 1103 |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Maryland  | 13b. COUNTY  | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br>770 W. Saratoga St. Apt. 21201 1103          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John L. McDonald  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Sadie Powell   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>111-44-7259   | 17. INFORMANT ADDRESS<br>Diane David 770 W. Saratoga St. Apt. 1103  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Squamous cell carcinoma of vagina,</u><br><u>metastatic locally, and to lungs</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>diabetes mellitus, type I</u>  |  |   |   |  |  |
| 19a. DATE OF OPERATION<br><u>NO</u>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>Sept 1</u> , 19 <u>84</u> , to <u>Nov 21</u> , 19 <u>84</u> , that (1) (we) lost<br>saw the deceased alive on <u>Nov 20</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (1) (we) (did) (did not) view the body after death.                                   |  |   |   |  |  |
| 22b. SIGNATURE<br><u>Barbara A. Conley</u>  |  | DEGREE<br><u>MD</u>   |   | 22c. DATE SIGNED<br><u>11/24/84</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>BARBARA A. CONLEY</u>   |  | 22e. ADDRESS<br><u>UMCC 225. Greene St. Balto md 21201</u>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  | 23b. DATE<br>11/28/84  | 23c. NAME OF CEMETERY OR CREMATORY<br>Eastview Mem. Pk.   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland              |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H 1101 E. North Avenue   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 26 1984  |   |  |  |
|   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Randall</u>   |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP \_\_\_\_\_  
DHMH - 16 50M 4/83  
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STANDARD OIL COMPANY OF INDIANA  
INCORPORATED IN INDIANA

STANDARD OIL COMPANY OF INDIANA

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NOV 30

STANDARD OIL COMPANY OF INDIANA

STANDARD OIL COMPANY OF INDIANA

NOV 30

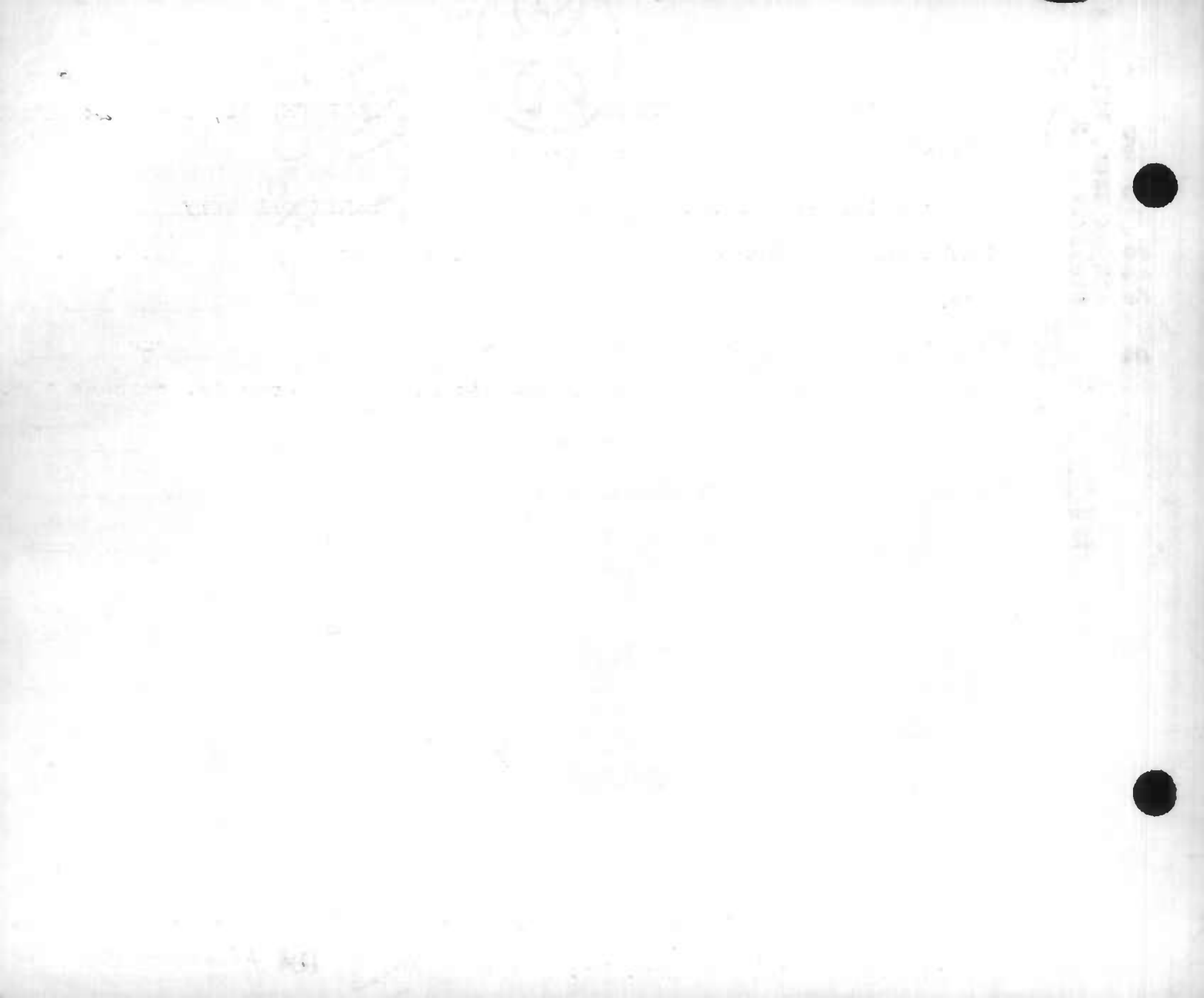
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STANDARD OIL COMPANY OF INDIANA

STANDARD OIL COMPANY OF INDIANA



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|---|--|---|---|
| 24. FUNERAL DIRECTOR<br>NAME<br>Hardesty Funeral Home | 12 Ridgely Ave.<br>ADDRESS<br>Annapolis, Md. 21401 | 25a. DATE REC'D BY REGISTRAR<br>NOV 15 1984 | REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall |
|---|--|---|---|



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 3 0 0 8 3  
REG. NO.

|  |  |   |  |   |                                 |  |
|--|--|---|--|---|---------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Allen Minor McFaddin   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 7 84 |   | 2b. HOUR<br>12 <sup>40</sup> AM |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>OCTOBER 13 1923   |                                 |  |
| 6. PLACE OF BIRTH<br>(STATE OR FOREIGN COUNTRY)<br>TEXAS   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. AGE (IN YEARS LAST BIRTHDAY)<br>61 YRS   |                                 |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. AGNES HOSPITAL |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |                                 |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>MANAGEMENT   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>INVESTMENTS  |  |   |                                 |  |
| 13a. STATE<br>MARYLAND   |  | 13b. COUNTY<br>HOWARD   |  | 13c. CITY OR TOWN<br>ELLICOTT CITY  |                                 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>CHARLES WALTER McFADDIN  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MABEL MAUREEN DUGGER   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                 |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW II  |  | 17. INFORMANT<br>ADDRESS<br>2543 NORTH FARM RD<br>CONSTANCE E. McFADDIN ELLICOTT CITY, MD 21043 |                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Metastatic prostatic carcinoma<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>6 yrs |  |   |  |   |                                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |  |   |  |   |                                 |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                 |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                 |  |
| 22a. I certify that (1) this hospital attended the deceased from _____, 19____, to _____, 19____, that (1) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.)  |  |   |  |   |                                 |  |
| 22b. SIGNATURE<br>Gregory F. McAuliffe, M.D.   |  | DEGREE<br>M.D.  |  | 22c. DATE SIGNED<br>11.7.84   |                                 |  |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 23b. ADDRESS<br>St Agnes Hospital Baltimore MD 21229  |  |   |                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b. DATE<br>11/9/84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>MOUNT VIEW CEMETERY                                       |                                 |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>SLACK FUNERAL HOME   |  | P.O. BOX 268<br>ADDRESS<br>ELLICOTT CITY, MD 21043  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 7 1984   |                                 |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8430084

FOR  
STATE  
REGISTRAR

REG. NO.

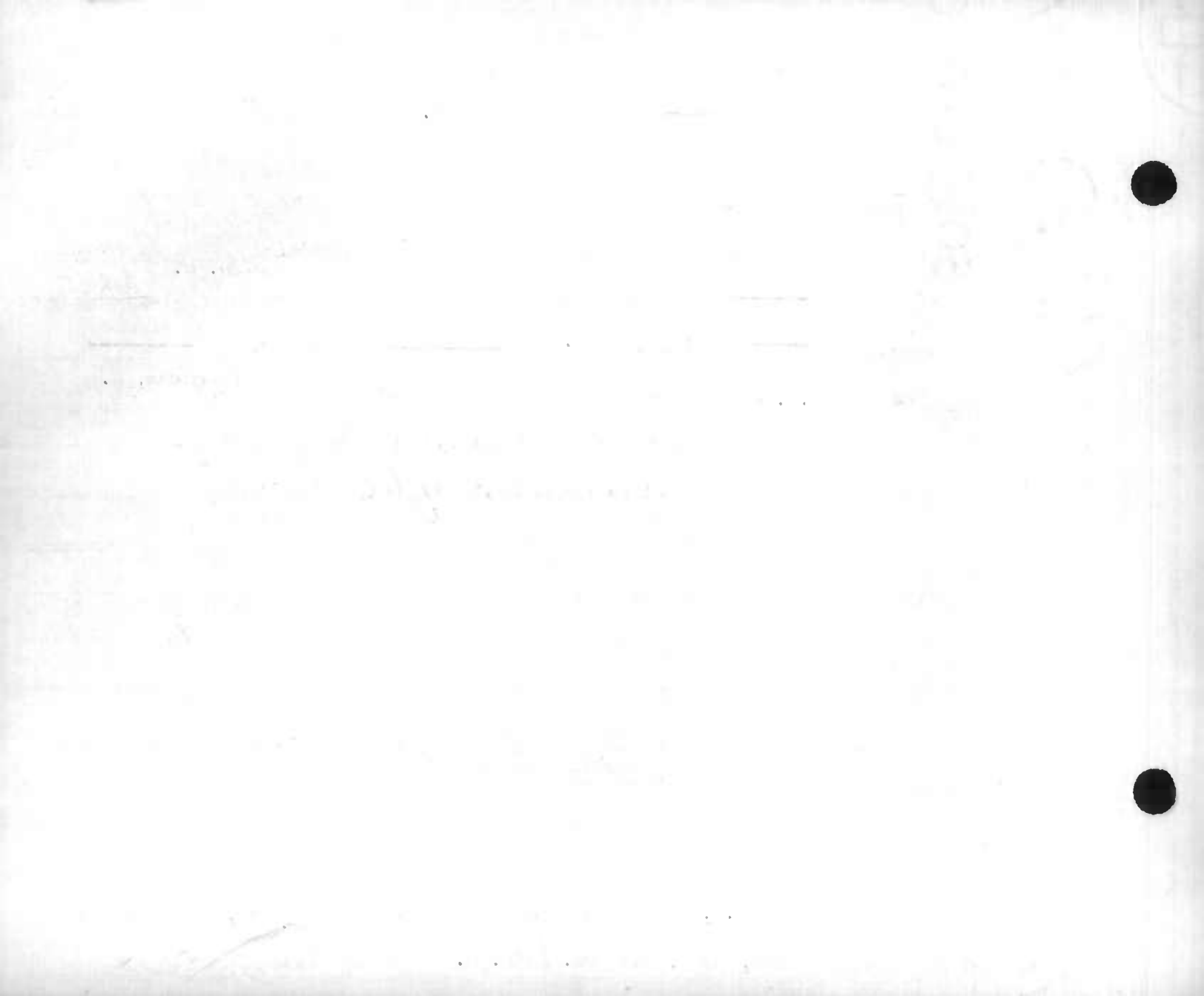
|   |  |   |   |  |   |
|---|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>GEORGE</b> <b>MCKAY Jr.</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 1 84</b>                                       |  | 2b. HOUR<br><b>11:25 AM</b>   |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 2 11</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS.                                    | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N Jersey</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALT. CITY</b> MD.                        |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALT.</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SOUTH BALT. GEN. HOSP.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Machinist</b>        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Ship Yard</b>   |
| 13a. STATE<br><b>MD</b>   |  |   | 13b. COUNTY<br><b>BALT.</b>   | 13c. CITY OR TOWN<br><b>BALT. City</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>GEORGE</b> <b>MCKAY Sr.</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>GEADYS</b> <b>Unknown</b> <b>MARTIN</b> |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>151010323</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>PAT. DOUGHERTY 7745 Pasadena Ave. #1122</b>           |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gastro-intestinal hemorrhage</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cirrhosis of the liver</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): _____ |  |   |   |  |   |
| MEDICAL CERTIFICATION   |  |   |   |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)              |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |
| 22a. I certify that (he) (this hospital) attended the deceased from <b>10/26</b> , 19 <b>84</b> , to <b>11/1</b> , 19 <b>84</b> , that (he) (we) last saw the deceased alive on <b>11/1</b> , 19 <b>84</b> , and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |  |   |
| 22b. SIGNATURE<br><b>M. Deringer</b>  |  |   | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>11/1/84</b>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>M. DERINGER</b>   |  |   | 22e. ADDRESS<br><b>3001 S. HANOVER ST. BALT. MD.</b>  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>Nov. 5, 1984</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Cross Cemetery</b>  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                    |  |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>McGully Funeral Home, 130 E. Fort Ave. Balto. Md.</b>  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 5 1984</b>  | 25b. REGISTRAR'S SIGNATURE<br><b>Lelia Davidson-Rodgers</b>                          |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |              |   |  |   |   |
|--|--------------|---|--|---|---|
| DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>William M. McKay  |              |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>MONTH DAY YEAR<br>11-27-84 |   | 2b. HOUR<br>M<br>10:51A   |
| 3. SEX<br>M  | 4. RACE<br>B | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>APR 7, 1921                       | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>63 YRS.                      | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS.<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>SOUTH CAROLINA  |              | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City   |              | 10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RETIRED |  |   |   |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>924 Veronica Avenue  |              | 12. KIND OF BUSINESS OR INDUSTRY  |  |   |   |
| 13a. STATE<br>MARYLAND   |              | 13b. COUNTY<br>BALTO  |  | 13c. CITY OR TOWN<br>BALTO  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>DARR MCKAY   |              | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>LOTTIE ROGERS          |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>YES   |              | 16b. SOCIAL SECURITY NO.<br>W.W. II 239 16 5656                         |  | 17. INFORMANT (BROTHER) ADDRESS<br>MR. HORACE MCKAY 924 Veronica Ave.   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |              |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |              |   |  |   |   |
| 19a. DATE OF OPERATION   |              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                       |  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |              | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)             |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |              |   |  |   |   |
| ACTUAL SIGNATURE<br>Margarita A. Korell, M.D.  |              | TITLE (SPECIFY)<br>M.D. Assistant                                       |  | DATE SIGNED<br>11-27-84   |   |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |              | ADDRESS<br>111 Penn Street  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL  |              | 23b. DATE<br>12-4-84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt ZION Cem   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>JOSEPH L. RUSS   |              | ADDRESS<br>2212 W. NORTH AVE  |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 3 1984   |   |
| 25b. REGISTRAR'S SIGNATURE   |              | 25c. REGISTRAR'S NAME   |  |   |   |



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SECTION 900



11-18-78

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 3 0 0 8 6

REG. NO.

|   |         |  |                  |   |                                 |   |  |  |                 |  |                 |  |  |
|---|---------|--|------------------|---|---------------------------------|---|--|--|-----------------|--|-----------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         | FIRST  | MIDDLE           | LAST  | 2a. DATE OF DEATH               |   |  |  | MONTH           | DAY  | YEAR            | 2b. HOUR                                     |  |
| MARY MCKNIGHT   |         |  |                  |   | 11 1 84                         |   |  |  |                 |  |                 | 5 PM   |  |
| 3. SEX  | 4. RACE |  | 5. DATE OF BIRTH |   | 6. AGE (IN YEARS LAST BIRTHDAY) |   |  |  | IF UNDER 1 YEAR |  | IF UNDER 24 HRS |  |  |
| FEMALE  | BLACK   |  | 3 8 1892         |   | 92 YRS                          |   |  |  | MONTHS          |  | DAYS            |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |  |  |                 | MD.  |                 |  |  |
| GEORGIA   |         | U.S.   |                  |   |                                 | Baltimore City  |  |  |                 |  |                 |  |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                  |   |                                 | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  |  |                 | 12b. KIND OF BUSINESS OR INDUSTRY                              |                 |  |  |
| Baltimore   |         | Provident Hospital   |                  |   |                                 | RETIRED   |  |  |                 |  |                 |  |  |
| 13a. STATE  |         | 13b. COUNTY  |                  | 13d. INSIDE CITY LIMITS?  |                                 | 13e. STREET ADDRESS   |  |  |                 |  |                 |  |  |
| MARYLAND  |         | BALTIMORE  |                  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                 | 3310 AUCHENTORRY RD.  |  |  |                 |  |                 |  |  |
| 14. FATHER'S NAME   |         |  |                  | 15. MOTHER'S MAIDEN NAME  |                                 |   |  |  |                 |  |                 |  |  |
| FIRST MIDDLE LAST   |         |  |                  | FIRST MIDDLE LAST   |                                 |   |  |  |                 |  |                 |  |  |
| UNKNOWN   |         |  |                  | SALLY HUGHES  |                                 |   |  |  |                 |  |                 |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |         |  |                  | 16b. SOCIAL SECURITY NO.  |                                 | 17. INFORMANT   |  |  |                 | ADDRESS  |                 |  |  |
|   |         |  |                  |   |                                 | CHART   |  |  |                 |  |                 |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:   |         |  |                  |   |                                 |   |  |  |                 |  |                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u>   |         |  |                  |   |                                 |   |  |  |                 |  |                 |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>pneumonia</u>   |         |  |                  |   |                                 |   |  |  |                 |  |                 |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Diabetes Mellitus</u>  |         |  |                  |   |                                 |   |  |  |                 |  |                 |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |         |  |                  |   |                                 |   |  |  |                 |  |                 |  |  |
| 19a. DATE OF OPERATION  |         |  |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                 |   |  | 20a. AUTOPSY?  |                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                 |  |  |
|   |         |  |                  |   |                                 |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                 | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                 |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |         |  |                  | 21b. TIME OF INJURY   |                                 |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                 |  |                 |  |  |
|   |         |  |                  | HOUR A.M. MONTH DAY YEAR  |                                 |   |  |  |                 |  |                 |  |  |
|   |         |  |                  | P.M. 19   |                                 |   |  |  |                 |  |                 |  |  |
| 21d. INJURY OCCURRED  |         |  |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                                 |   |  | 21f. LOCATION  |                 |  |                 |  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |         |  |                  |   |                                 |   |  | STREET CITY OR TOWN COUNTY STATE   |                 |  |                 |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11-01</u> , 19 <u>84</u> , to <u>11-01</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>11-01</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |         |  |                  |   |                                 |   |  |  |                 |  |                 |  |  |
| 22b. SIGNATURE  |         |  |                  | DEGREE  |                                 |   |  | 22c. DATE SIGNED   |                 |  |                 |  |  |
| SHER AFZAL HASHMI   |         |  |                  | MD  |                                 |   |  | 11-01-84   |                 |  |                 |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |         |  |                  | 22e. ADDRESS  |                                 |   |  |  |                 |  |                 |  |  |
| SHER AFZAL HASHMI   |         |  |                  | 2600 LIBERTY HEIGHTS AVE  |                                 |   |  |  |                 |  |                 |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |         |  |                  | 23b. DATE   |                                 | 23c. NAME OF CEMETERY OR CREMATORY                            |  | 23d. LOCATION  |                 |  |                 |  |  |
| ENTOMBMENT  |         |  |                  | 11/5/84   |                                 | ARBUS MCM.  |  | BALTIMORE COUNTY   |                 |  |                 |  |  |
| 24. FUNERAL DIRECTOR  |         |  |                  | 25a. DATE REC'D. BY REGISTRAR   |                                 |   |  | 25b. REGISTRAR   |                 |  |                 |  |  |
| NAME  |         |  |                  | ADDRESS   |                                 |   |  |  |                 |  |                 |  |  |
| E.L. Phillips   |         |  |                  | 1721 N. MONROE ST.  |                                 |   |  | NOV 5 1984   |                 |  |                 |  |  |

BP



Baltimore City

Baltimore General Hospital

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 3 0 0 8 7

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>CATHERINE E. MCMILLON</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 12, 1984</b>                        |   | 2b. HOUR<br><b>10:45A</b>                                    |
| 3. SEX<br><b>FEMALE</b>  | 4. RACE<br><b>BLACK</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 15 1915</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Delaware</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEKEEPER</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>HOSPITAL</b>         |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Albert Dunning</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>May White</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No.</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>240-10-7622</b>  |  | 17. INFORMANT<br><b>Ordellia Smith</b> ADDRESS<br><b>2417 W. Cold Spring La. Baltimore, Md. 21215</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Stage IV Adenocarcinoma of ovary</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 yrs</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>4/83</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>recurrent cancer</b>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)                        |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-2</b> , 19 <b>84</b> , to <b>11-12</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>11-12</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                             |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Rita Meeks M.D.</b>   |  | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>11-12-84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Rita Meeks M.D.</b>  |  | 22e. ADDRESS<br><b>9000 Franklin Square Dr.</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11/16/1984</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Memorial Park</b>                                    |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |  | 23e. DATE REC'D. BY REGISTRAR<br><b>NOV 14 1984</b>   |  |   |  |
| 24. FUNERAL HOME OR OTHER PERSON TO WHOM THIS CERTIFICATE IS LOANED<br>NAME ADDRESS<br><b>Nutter &amp; Sons 2501 Gwynns Falls Parkway<br/>Funeral Home Inc. Baltimore, Maryland 21216</b>  |  | 25. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please return pages 3 and 4 to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 this is a violent injury, or other traumatic event, the medical examiner must be notified of same.

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10/1/1974

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 3 0 0 8 8

REG. NO.

FOR  
1. STATE  
REGISTRAR

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>JAMES T. McMORRIS  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>November 5, 1984                      |  | 2b. HOUR<br>10:50 P.M.   |
| 3. SEX<br>Male  | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct. 1, 1912  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS.   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Ohio   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                            |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2616 N. Calvert Street |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Owner | 12b. KIND OF BUSINESS OR INDUSTRY<br>Dairy Farm                                      |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD   |   |   | 13b. COUNTY   | 13c. CITY OR TOWN<br>Baltimore   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James McMORRIS  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Pearl Marshall           |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   IF YES, GIVE WAR OR DATES<br>No  |   | 16b. SOCIAL SECURITY NO.<br>268 01 1997   |   | 17. INFORMANT<br>Mrs. Mary Morris, Same  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardio-respiratory arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic ca of prostate</u><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) |   |   |   |  |  |
| MEDICAL CERTIFICATION   |   |   |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (1) (name) attended the deceased from 5-8-1980 to 11-5-1984, that (name) lost saw the deceased alive on 9-10-1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (we did not) view the body after death.)   |   |   |   |  |  |
| 22b. SIGNATURE<br>Dr. Horst K. Schirmer, MD   |   | DEGREE  |   | 22c. DATE SIGNED<br>X 16 84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |   | 22e. ADDRESS<br>201 E. University Pkwy., Balto., MD   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  | 23b. DATE<br>11/10/84   | 23c. NAME OF CEMETERY OR CREMATORY<br>Edgewood Cemetery   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Ashtabula, Ohio                        |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., MD 21212  |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 7 1984<br>25b. REGISTRAR'S SIGNATURE<br>J. Davidson-Rendell  |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

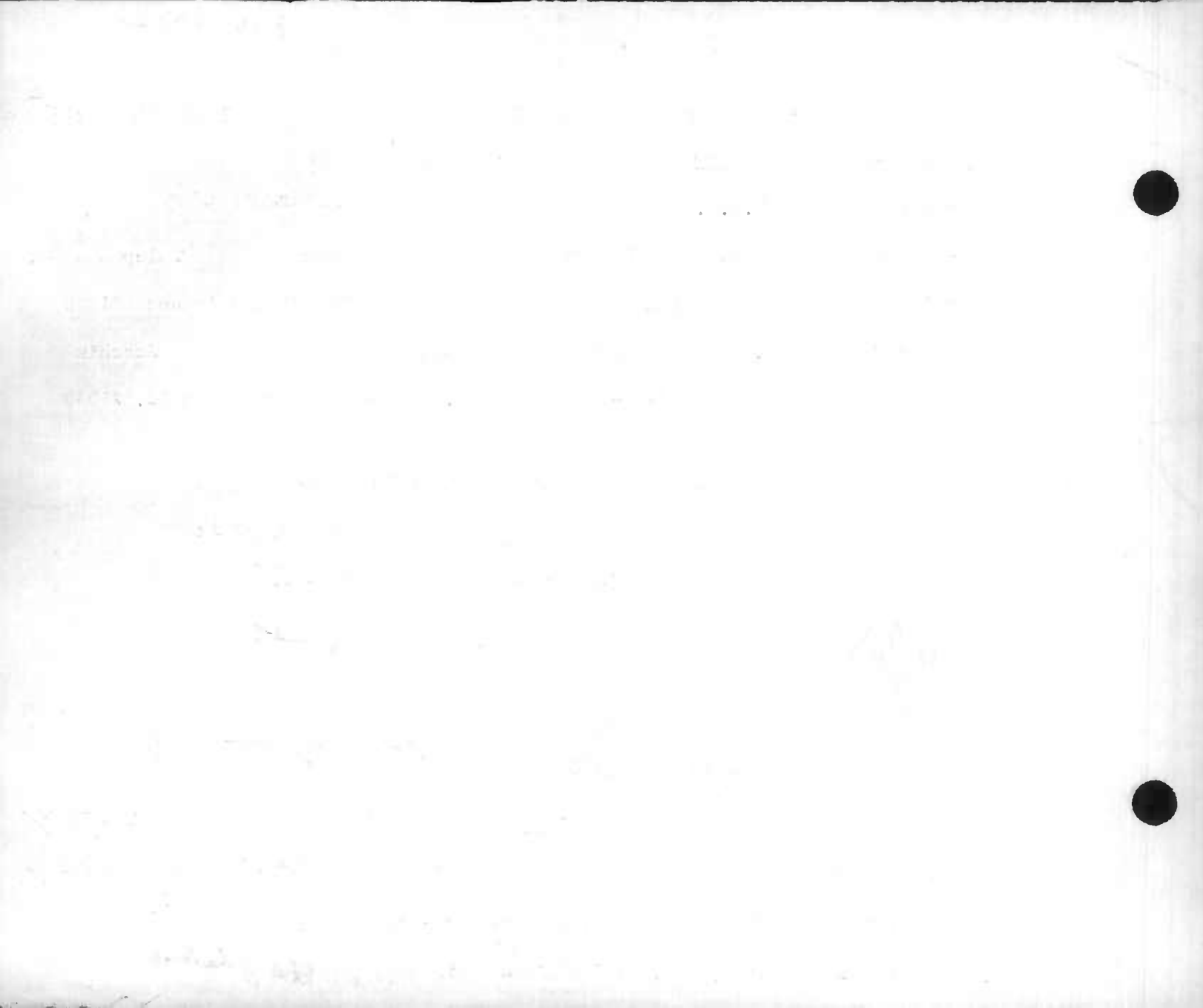
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





REG. NO.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 84 30090  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>REV. Toby</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>11 - 7 - 84</b>  |  |   |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>Black</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>4 18 1891</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>93</b> YRS. MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maxton, N. C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lafayette Nursing Center</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Minister</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>A.M.E. Church</b>  |  |
| 13a. STATE <b>Maryland</b>   |  | 13b. COUNTY <b>Baltimore</b>   |  | 13c. CITY OR TOWN <b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 13e. STREET ADDRESS <b>2637 Barclay Street</b>   |  | 13f. CITY OR TOWN <b>Baltimore, Maryland 21228</b>   |  |  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Toby Mc Queen</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Annie Mc Queen</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>   |  | 16b. SOCIAL SECURITY NO. <b>WW II 213-07-8131</b>  |  | 17. INFORMANT <b>Maggie M. Young</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b>                                       |  | DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASHD</b>   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>IMMEDIATE</b>  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost  |  | DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>CVA, seizure disorder, Diabetes Mellitus</b>                   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>10-26-84</b> P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21d. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| 21e. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK   |  | 21f. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)   |  | 21g. LOCATION STREET CITY OR TOWN COUNTY STATE   |  | 21h. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-7-84</b> to <b>11-7-84</b> , that (I) (we) lost <b>11-7-84</b> above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE <b>Shaukat</b>  |  | DEGREE <b>M.D.</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED <b>11-8-84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SHAUKAT Y. KHAN</b>   |  | M.D.   |  | 22e. ADDRESS <b>1528 KING WILLIAM DRIVE, Balt, MD 21228</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>11/12/1984</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Park</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>  |  |
| 24. FUNERAL HOME OR NAME <b>Nutter &amp; Sons</b>  |  | 25a. ADDRESS <b>2501 Gwynns Falls Parkway</b>  |  | 25b. DATE REC'D. BY REGISTRAR <b>NOV 13 1984</b>   |  | 25c. REGISTRAR'S SIGNATURE <b>John Anderson-Randell</b>   |  |
| Funeral Home Inc.  |  | Baltimore, Maryland 21216  |  |  |  |   |  |

REV.

Boston, N. C.

U. S. A.

Baltimore City

Baltimore

Baltimore Nursing Center

Minister

A.W.L. Church

Maryland

Baltimore

X

Baltimore, Maryland

2027 Barclay Street

Today

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Amie

NO Green

Yes

NO 12

212-7-0122

Rev. P. Young

Baltimore

611 Cherry Street, Apt. 2, Baltimore, Maryland 21225

Burial

Kutter & Sons

2501 Gwynne Falls Parkway

Baltimore, Maryland 21216

1117/11234 Art & Memorial Park

Baltimore, Maryland

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

84 30091

REG. NO.

|   |                         |   |   |   |                          |
|---|-------------------------|---|---|---|--------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MAXWELL MC TAGGART</b> |                         |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOV 18 1984</b> |   | 2b. HOUR<br><b>1 P M</b> |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 3 1907</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.                                   |                          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Canada</b>                            |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>                   |                          |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Good Samaritan Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Salesman</b> |                          |
| 13a. STATE<br><b>Maryland</b>   |                         | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |                          |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>? ? McTaggart</b>                        |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>   |   |   |                          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>    |                         | 16b. SOCIAL SECURITY NO.<br><b>WW 11 207-07-9401</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Mr John P McTaggart 1804 Dalhousie Ct 21234</b>      |                          |

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO-RESPIRATORY ARREST</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>GASTRO-INTESTINAL BLEED</b>   |  |   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CYRRHOSIS OF LIVER</b>  |  |   |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0

|  |  |  |  |  |   |
|--|--|--|--|--|---|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that <del>he</del> (this hospital) attended the deceased from <b>10/25</b> , 19 <b>84</b> , to <b>11/18</b> , 19 <b>84</b> , that (1) <del>was</del> lost<br>saw the deceased alive on <b>11/18</b> , 19 <b>84</b> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated<br>above, <del>(I/we)</del> (did) <del>not</del> view the body after death. |  |  |  |  |   |
| 22b. SIGNATURE<br><b>Thomas S. Miller</b><br><b>THOMAS S. MILLER</b>   |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>4/15/84</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS<br><b>THOMAS S. MILLER GSH</b>                            |  |  |   |

|  |                              |  |   |
|--|------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>                       | 23b. DATE<br><b>11-21-84</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview</b>    | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b> |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J. Ruck, Inc. 5305 Harford Road</b> |                              | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 20 1984</b>      |   |
|  |                              | 25b. REGISTRAR'S SIGNATURE<br><b>P. Davidson-Rendell</b> |   |

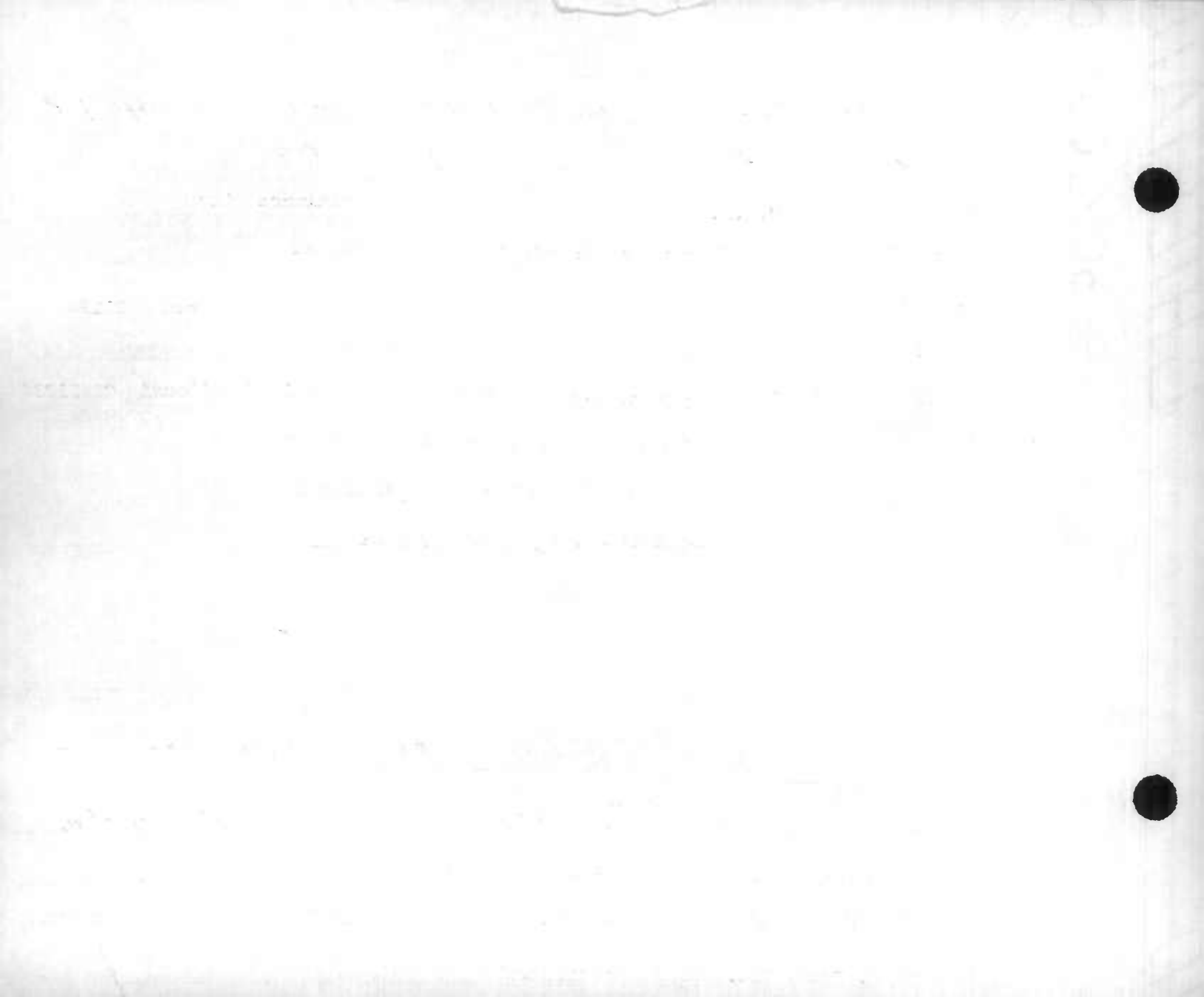
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8430092

REG. NO.

|  |  |  |  |   |   |   |  |  |  |
|--|--|--|--|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Elizabeth B. Meghan</b><br><b>Elizabeth Meghan</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11 17 84</b>                    |   |   | 2b. HOUR<br><b>4:45 A.M.</b>  |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Caucasin</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>5 24 96</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Secretary</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Life Ins. Co</b>   |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Balto.</b>   |  | 13c. CITY OR TOWN<br><b>Catonsville</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>1605 Beechwood Avenue 21228</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James Bennett</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Nancy Baker</b>   |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b> IF YES, GIVE WAR OR DATES   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>165-50-5803</b>  |   | 17. INFORMANT ADDRESS<br><b>Mr. Frederick Meghan Same as # 13</b>                               |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Aspiration Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bilateral Pleural Effusion</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>CVA</b> |  |  |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Coronary art. disease, arrhythmia, CVA @ Rt Hemiplegia &amp; Aphasia</b>   |  |  |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10/30</b> , 19 <b>84</b> , to <b>11/17</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>11/17</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                   |  |  |  |   |   |   |  |  |  |
| 22a. SIGNATURE<br><b>Embarsh</b>   |  |  |  |   |   | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>11/17/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |   |   | 22e. ADDRESS  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>11-20-84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park Cem.</b> |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Woodlawn Balto Md</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>MacNabb Funeral Home Catonsville Md</b>   |  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 21 1984</b>   |  |  |  |
|  |  |  |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Jane Davidson</b>  |  |  |  |


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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





20%

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8430093

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |   |  |  |  |  |  |  |  |
|---|--|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LORETTA Margaret MEHRING</b>         |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>11 20 84</b>                  |  |  | 2b. HOUR <b>12:30 A.M.</b>   |  |  |  |  |
| 3. SEX <b>FEMALE</b>  |  | 4. RACE <b>WHITE</b>   |   | 5. DATE OF BIRTH MONTH DAY YEAR <b>9 19 12</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.                               |  | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS. HOURS MIN. |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>                   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.               |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Francis Scott Key Medical Center</b> |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Housework</b>                 |  |  |
| 13a. STATE <b>Maryland</b>  |  |  | 13b. COUNTY <b>Baltimore</b>                                      |  | 13c. CITY OR TOWN <b>Baltimore</b>                                   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE <b>3211 Dillon Street 21224</b> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Michael Mehring</b>                  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Frances Amrhein</b> |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b> |  |  | 16b. SOCIAL SECURITY NO. <b>212-01-6596</b>                       |  | 17. INFORMANT ADDRESS <b>Anna Frampton 601 S. Eaton Street 21224</b> |  |  |  |  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**CARDIORESPIRATORY ARREST**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

**MINUTES**

DUE TO, OR AS A CONSEQUENCE OF

(b) **UNKNOWN ? ARHYTHMIA**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

**SEVERE PERIPHERAL VASCULAR DISEASE / GOUT, NON-TOLC**

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11 19 84</b> P.M.   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/16</b> , 19 <b>84</b> , to <b>11/20</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>11/19</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE <b>William M. Simpson, Jr.</b>   |  | DEGREE <b>MD</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED <b>11/20/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William M. Simpson, Jr.</b>  |  | 22e. ADDRESS <b>Mason F. Lord Chronic Hosp.</b>                     |  |  |  |   |  |

|  |  |                           |  |   |  |   |  |
|--|--|---------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>11-24-84</b> |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart Cem.</b> |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Dundalk, Balto. Co., Md.</b> |  |
| 24. FUNERAL DIRECTOR NAME <b>Charles S. Zeiler &amp; Son Inc.</b> ADDRESS <b>901 S. Conkling St.</b> |  |                           |  | 25a. DATE REC'D. BY REGISTRAR <b>NOV 23 1984</b>            |  | 25b. REGISTRAR'S SIGNATURE <b>Johanna Davidson-Randall</b>              |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Physicians be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 8-4 30094   |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>AGNES MAY MILES  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>11 24 84   |  |  |  |
| 2b. HOUR<br>9:20 P.M.   |  |  |  |  |  |  |  |
| 3 SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Oct. 8, 1896  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>88 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Union Memorial Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Substitute Teacher   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Teacher-Balto. City   |  |
| 13a. STATE<br>MD  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Balto.  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>(Unknown) Todd   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>(Unknown)  |  | 13e. STREET ADDRESS / ZIP CODE<br>3915 Beech Avenue, 21211   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>215 40 4711  |  | 17. INFORMANT ADDRESS<br>Patrick H. Miles, Marriottsville, MD  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>CA of body of American invading duodenal &amp; liver metastasis.</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>Hypertension Hypothyroidism</u>   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br>11/21/84  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>GI Bleed   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/19</u> , 19 <u>84</u> , to <u>11/24</u> , 19 <u>84</u> , that (I) (we) lost<br>saw the deceased alive on <u>11/24</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Stephanie Mason</u>  |  | DEGREE<br><u>MD</u>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input checked="" type="checkbox"/><br>PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>11/24/84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Stephanie Mason</u>   |  | 22e. ADDRESS<br><u>Union Memorial Hosp., BALTO. mry</u>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>11/27/84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Druid Ridge  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Pikesville, MD   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., MD 21212  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 26 1984   |  |  |  |
|   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>John L. ...</u>   |  |  |  |

4800 York Road, E. Inc., MD 21212  
 Henry W. Jenkins & Sons Co.  
 11/27/64 Fruit Ridge  
 Pikesville, MD

4800 York Road, E. Inc., MD 21212  
 Henry W. Jenkins & Sons Co.  
 11/27/64 Fruit Ridge  
 Pikesville, MD

No. 10-1711 Patrick H. Jones, Pikesville, MD  
 (Unknown) Total (Unknown)  
 MD 21212  
 3015 Beech Avenue, 21211  
 Unionville, MD 21211  
 USA  
 White  
 1001 S. 1001  
 B. J. Jones, City



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 3 0 0 9 5

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |   |   |  |
|--|--|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>James A Melton  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 20 84 |   | 2b. HOUR<br>6:52 P.M.   |   |  |
| 3. SEX<br>male   |  | 4. RACE<br>white  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 19 1910  |   | 6. AGE (IN YEARS (LAST BIRTHDAY))<br>74 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Mercy Hospital, Balto. Md. |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Lift Truck Operator         |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br>Baltimore  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James D. Melton  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Margaret LeClare   |   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215-01-0280  |   | 17. INFORMANT<br>ADDRESS<br>Mrs. Catherine M. Melton, Same as above   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Congestive Heart Failure<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) Pneumonia<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |   |   |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                            |  |   |   |   |   |   |  |
| 22b. SIGNATURE<br>G. Pokrywka MD   |  | 22c. DATE SIGNED  |   |   |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>G. Pokrywka MD  |  | 22e. ADDRESS<br>Mercy Hospital  |   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>Nov. 24, 1984  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                                |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>McGilly F.H.   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 23 1984  |   | 25b. REGISTRAR'S SIGNATURE<br>F.H. McGilly  |   |   |  |

BP

June 11, 1900

Mr. J. H. ...

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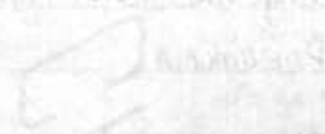
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20% COLLECT





DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

|   |  |  |   |   |  |  |  |
|---|--|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>AMELIA MAY MEYER</b>   |  |  | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>22</b> YEAR <b>84</b> |   |  | 2b. HOUR <b>8:35<sup>a</sup></b> MIN <b>M</b>  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>  |   | 5. DATE OF BIRTH<br>MONTH <b>03</b> DAY <b>31</b> YEAR <b>27</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>57</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PENNSYLVANIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSPITAL</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>TELEPHONE OPERATOR</b>                              |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>---</b>  |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST <b>JOSEPH</b> MIDDLE <b>J.</b> LAST <b>MEYER</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>EDA</b> MIDDLE <b>LORENZ</b> LAST <b>LORENZ</b>   |   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>   |  |  |  |
| 17. INFORMANT<br><b>EDA A. BASS</b>   |  | 18. SOCIAL SECURITY NO.<br><b>175-22-3735</b>  |   |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>11/16/84</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Recurrent Meningioma</b>  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/13/84</b> to <b>11/22/84</b> , that (I) (we) last saw the deceased alive on <b>11/22/84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Thomas B. Blake III M.D.</b>   |  |  |   | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>11/22/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Thomas B. Blake III M.D.</b>  |  |  |   | 22e. ADDRESS<br><b>6313 Mount Ridge<br/>Catonsville Md.</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>11-26-84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MEADOWRIDGE MEM. PK.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ELKCRIDGE HOWARD MARYLAND</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HUBBARD FUNERAL HOME, INC.</b>   |  |  |   | ADDRESS<br><b>4107 WILKENS AVE.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 26 1984</b>  |  |
|   |  |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Rand</b>  |  |  |  |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

*[Faint, illegible markings]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 4 3 0 0 9 7   |  |   |   |
|---|--|--|--|---|--|---|---|
| FOR<br>1. STATE<br>REGISTRAR  |  |  |  | REG. NO.  |  |   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ROSIE Rose MIDGEETT</b>  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-19-84</b>  |  | 2b. HOUR<br><b>9:52 A M</b>   |   |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 2 06</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Balto</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Luthern Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |
| 13a. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  | 13b. STREET ADDRESS<br><b>501 Dolphin St 21217</b>  |  |   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Wilbert Walter</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Gracie Walter</b>   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>220-10-6114</b>  |  | 17. INFORMANT<br><b>Lillie Henry</b>  |  | ADDRESS<br><b>601 Wyanoke Ave. (18)</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiogenic shock.</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Probable MI.</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Respiratory failure.</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <b>COPD. Pneumonia.</b> |  |  |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>11 19 84</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/12</b> , 19 <b>84</b> , to <b>11/19</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>11/19</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |   |
| 22b. SIGNATURE<br><b>BICH T DUONG</b> MD  |  |  |  | 22c. DATE SIGNED<br><b>11/19/84</b>   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BICH T DUONG</b>  |   |
| 22e. ADDRESS<br><b>LUTHERAN HOSPITAL</b>  |  |  |  | 22f. DATE REC'D. BY REGISTRAR   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11-24-84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King, S Mem. Pk.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Randallstown MD.</b>   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Chas. A. Rice FSPA</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 26 1984</b>   |  |   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Chas. A. Rice</b>  |  |  |  | 25c. ADDRESS<br><b>1300 Eutaw Place</b>   |  |   |   |

THE UNIVERSITY OF CHICAGO  
LIBRARY

CHICAGO, ILL.

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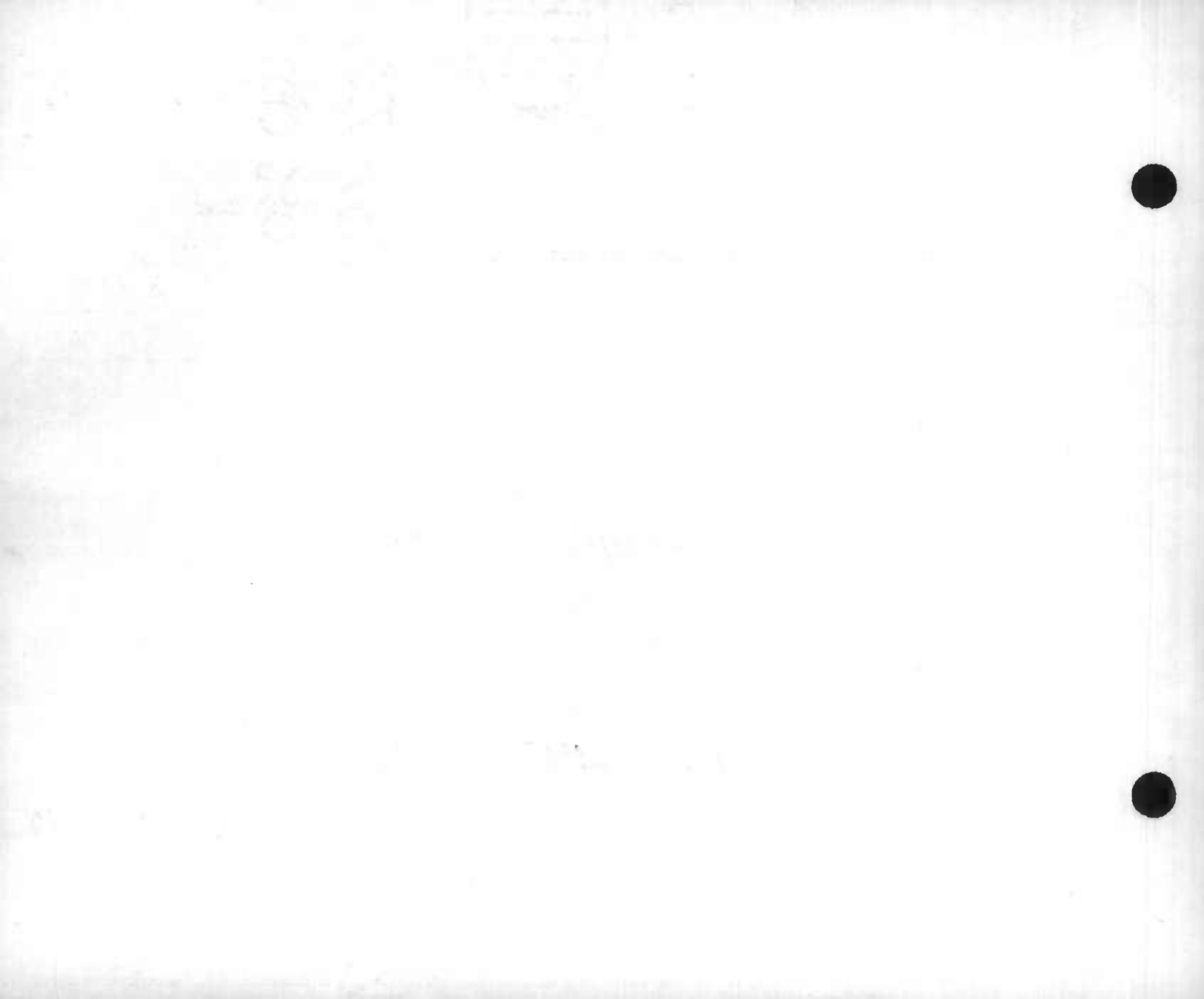
LIBRARY



CHICAGO, ILL.

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HILLER, DORA  
808812 S301B MED S  
10/16/84 S WALKER  
1705 W. NORTH AVE  
21217 F 11/98079230

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low number on this certificate has been assigned by the Registrar and should be detached for use of the hospital or attending physician. The low number on this certificate has been assigned by the Registrar and should be detached for use of the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been assigned by the Registrar, it should be detached for use of the funeral director. The low number on this certificate has been assigned by the Registrar and should be detached for use of the funeral director.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |  |
|---|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR   |  | 2b. HOUR  |  | P  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST MIDDLE LAST  |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR  |  | 2b. HOUR                                       |  |
| JOHN W. MILLER  |  |  |  | NOVEMBER 26, 1984  |  | 12:05   |  | P  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR                                |  |
| Male  |  | Cauc.  |  | MONTH DAY YEAR   |  | 54  |  | MONTHS DAYS                                    |  |
| BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  | 10. IF UNDER 24 HRS                            |  |
| Pa.   |  | U.S.A.   |  |  |  | BALTIMORE CITY  |  | HOURS MIN.                                     |  |
| CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |
| BALTIMORE   |  | THE JOHNS HOPKINS HOSPITAL   |  | Crane operator   |  | Beth. Steel Co  |  |  |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS / ZIP CODE                 |  |
| Maryland  |  |  |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 111 Janney St. 21224                           |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS                          |  |
| FIRST MIDDLE LAST   |  | FIRST MIDDLE LAST  |  | no   |  | 217-26-3794   |  | Robert Schwarz - 3109 Beverly St. Balto. 21214 |  |
| Merril - Miller   |  | Laura - Morehand   |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Post-Obstructive Pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Squamous Cell Ca of Lung</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>3 days</u><br><u>10 mos.</u> |  |  |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><u>Hypotension / Respiratory Acidosis</u>   |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |  |  |
|   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/23</u> , 19 <u>84</u> , to <u>11/26/84</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>11/26</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                        |  | 22b. SIGNATURE<br><u>Charles B. Treasure</u><br>DEGREE<br>M.D.<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><u>11/26/84</u>  |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Charles B. Treasure</u>   |  | 22e. ADDRESS<br><u>600 N. Wolfe Baltimore, MD 21205</u>  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |  |  |
| Burial  |  | 11/29/84   |  | Oak Lawn   |  | Baltimore Md.   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Walter Dabrowski</u>   |  | ADDRESS<br><u>1005 Dundalk Ave. 21224</u>  |  | 25a. DATE REC'D BY REGISTRAR<br><u>NOV 29 1984</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                    |  |  |  |



1958 FEB 28  
11:11 AM  
JAN 30 1958

1000 BROADWAY - 1000 BROADWAY  
JAN 30 1958

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

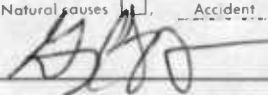
BP \_\_\_\_\_

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |                  |                |   |  |  |  |   |                |  |  |   |  |  |                 |                                   |  |   |  |  |  |
|--|--|------------------|----------------|---|--|--|--|---|----------------|--|--|---|--|--|-----------------|-----------------------------------|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |                  | FIRST<br>Linda |   |  | MIDDLE<br>Marie                                |  |   | LAST<br>Miller |  |  | 2a. DATE KNOWN OF DEATH<br><input checked="" type="checkbox"/> MONTH DAY YEAR<br>11/30/1984 |  |  | 2b. HOUR<br>M   |                                   |  |   |  |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White |                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 5 83  |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>1 YRS. |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN   |                | IF UNDER 24 HRS.                                   |  | 2c. DATE PRONOUNCED DEAD<br>11/ 30/ 1984  |  |  | 2d. HOUR<br>A M |                                   |  |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  |                  |                | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD                                  |  |  |                 |                                   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |                  |                | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>506 S. Pulaski Street |  |  |  |   |                |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Infant                     |  |  |                 | 12b. KIND OF BUSINESS OR INDUSTRY |  |   |  |  |  |
| 13a. STATE<br>Maryland   |  |                  |                | 13b. COUNTY<br>-----  |  | 13c. CITY OR TOWN<br>Baltimore                 |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                | 13e. STREET ADDRESS<br>506 South Pulaski St. 21223 |  |   |  |  |                 |                                   |  |   |  |  |  |
| 14. FATHER'S NAME<br>Richard Sloan Miller Sr.  |  |                  |                | 15. MOTHER'S MAIDEN NAME<br>Barbara Faye James  |  |  |  |   |                |  |  |   |  |  |                 |                                   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  |                  |                | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>None   |  |  |  | 17. INFORMANT ADDRESS<br>Jacob F. James 740 E. 30th Street 21218  |                |  |  |   |  |  |                 |                                   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>8902 IMMEDIATE CAUSE (a) <u>Smoke and Soot Inhalation</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u><br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |                  |                |   |  |  |  |   |                |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                 |                                   |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                  |                |   |  |  |  |   |                |  |  |   |  |  |                 |                                   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |                  |                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |   |                |  |  |   |  |  |                 |                                   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |                | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>1:46xx 11/30/84  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>subject in housefire   |                |  |  |   |  |  |                 |                                   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |                  |                | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>home   |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>506 S. Pulaski St., Balto. City, Md.   |                |  |  |   |  |  |                 |                                   |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                  |                |   |  |  |  |   |                |  |  |   |  |  |                 |                                   |  |   |  |  |  |
| ACTUAL SIGNATURE<br>  |  |                  |                | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER  |  |  |  |   |                |  |  |   |  | DATE SIGNED<br>11/30/84                      |                 |                                   |  |   |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Gregory R. Kauffman, M.D.  |  |                  |                | ADDRESS<br>111 Penn St.   |  |  |  |   |                |  |  |   |  |  |                 |                                   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation   |  |                  |                | 23b. DATE<br>12-3-84  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Memorial Park  |                |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Westview, Balto. Co., Md.                     |  |  |                 |                                   |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Charles S. Zeiler & Son Inc.   |  |                  |                |   |  |  |  |   |                | ADDRESS<br>901 S. Conkling St.                     |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 4 1984  |                 |                                   |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall                                |  |  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

3 0 1 0 2

|   |         |  |  |  |  |   |  |   |  |                                   |  |                               |  |   |  |  |  |
|---|---------|--|--|--|--|---|--|---|--|-----------------------------------|--|-------------------------------|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         | FIRST  |  | MIDDLE   |  | LAST  |  | 2a. DATE KNOWN OF DEATH   |  | MONTH                             |  | DAY                           |  | YEAR  |  | 2b. HOUR                                     |  |
| Richard Sloan Miller, Jr.   |         |  |  |  |  |   |  | 11/30/84  |  |                                   |  |                               |  |   |  | 2:00   |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)  |  | IF UNDER 1 YR   |  | IF UNDER 24 HRS.  |  | 7c. DATE PRONOUNCED DEAD          |  | MONTH                         |  | DAY   |  | YEAR   |  |
| Male  | White   | 11 7 77  |  | 7 YRS.   |  |   |  |   |  | 11/30/84                          |  |                               |  |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |   |  |                                   |  |                               |  |   |  |  |  |
| Maryland  |         | U.S.A.   |  |  |  | Baltimore City, MD.   |  |   |  |                                   |  |                               |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)        |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |                               |  |   |  |  |  |
| Baltimore   |         | 506 S. Pulaski St.   |  |  |  | Student   |  |   |  | School                            |  |                               |  |   |  |  |  |
| 13a. STATE  |         | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS   |  |                                   |  |                               |  |   |  |  |  |
| Maryland  |         |  |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 506 South Pulaski St. 21223   |  |                                   |  |                               |  |   |  |  |  |
| 14. FATHER'S NAME   |         |  |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME  |  |                                   |  |                               |  |   |  |  |  |
| Richard Sloan Miller Sr.  |         |  |  |  |  |   |  | Barbara Faye James  |  |                                   |  |                               |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |         |  |  | 16b. SOCIAL SECURITY NO.   |  |   |  | 17. INFORMANT ADDRESS   |  |                                   |  |                               |  |   |  |  |  |
| No  |         |  |  | None   |  |   |  | Jacob F. James 740 E. 30th. St. 21218   |  |                                   |  |                               |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         |  |  |  |  |   |  |   |  |                                   |  |                               |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I DEATH WAS CAUSED BY:   |         |  |  |  |  |   |  |   |  |                                   |  |                               |  |   |  |  |  |
| IMMEDIATE CAUSE (a) Smoke and Soot Inhalation   |         |  |  |  |  |   |  |   |  |                                   |  |                               |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |         |  |  |  |  |   |  |   |  |                                   |  |                               |  |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |         |  |  |  |  |   |  |   |  |                                   |  |                               |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |         |  |  |  |  |   |  |   |  |                                   |  |                               |  |   |  |  |  |
| (c)   |         |  |  |  |  |   |  |   |  |                                   |  |                               |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |         |  |  |  |  |   |  |   |  |                                   |  |                               |  |   |  |  |  |
| 19a. DATE OF OPERATION  |         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  |                                   |  |                               |  | 20. AUTOPSY?  |  |  |  |
|   |         |  |  |  |  |   |  |   |  |                                   |  |                               |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |                                   |  |                               |  |   |  |  |  |
| 1:46xx 11/30/84   |         |  |  | subject in housefire   |  |   |  |   |  |                                   |  |                               |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |         |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |   |  | 21f. LOCATION   |  |                                   |  |                               |  |   |  |  |  |
| home  |         |  |  | 506 S. Pulaski St., Balto. City, Md.   |  |   |  |   |  |                                   |  |                               |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural cause <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |         |  |  |  |  |   |  |   |  |                                   |  |                               |  |   |  |  |  |
| ACTUAL SIGNATURE  |         |  |  | TITLE (SPECIFY)  |  |   |  |   |  |                                   |  |                               |  | DATE SIGNED   |  |  |  |
| Gregory R. Kauffman, M.D.   |         |  |  | M.D. Assistant MEDICAL EXAMINER  |  |   |  |   |  |                                   |  |                               |  | 11/30/84  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |         |  |  | ADDRESS  |  |   |  |   |  |                                   |  |                               |  |   |  |  |  |
| Gregory R. Kauffman, M.D.   |         |  |  | 111 Penn St.   |  |   |  |   |  |                                   |  |                               |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |         |  |  | 23b. DATE  |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |                                   |  | 23d. LOCATION                 |  |   |  |  |  |
| Cremation   |         |  |  | 12-3-84  |  |   |  | Westview Memorial Park  |  |                                   |  | Westview, Balto. Co., Md.     |  |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME   |         |  |  |  |  |   |  |   |  |                                   |  | 25a. DATE REC'D. BY REGISTRAR |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |
| Charles S. Zeiler & Son Inc.  |         |  |  |  |  |   |  |   |  |                                   |  | DEC 4 1984                    |  | Julia Friedman Anderson   |  |  |  |

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Shaw

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U.S.A.

School

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James

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William

James

None

1921/2

James



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                  |  |   |  |   |  |  |                         | REG. NO. 30103   |  |
|--|--|------------------|--|---|--|---|--|--|-------------------------|--|--|
| 1- STATE REGISTRAR   |  |                  |  |   |  |   |  |  |                         |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Richard Sloan Miller, Sr.  |  |                  |  |   |  |   |  |  |                         | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR<br>11/30/ 19 84 |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>12 18 38   |  | 6. AGE (IN YEARS) MONTHS DAYS HOURS MIN<br>45 YRS.  |  | 7c. DATE PRONOUNCED DEAD<br>11/30 1984   |                         | 2b. HOUR<br>2:00   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>West Virginia   |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                         | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>506 S. Pulaski St. |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Laborer   |                         | 12b. KIND OF BUSINESS OR INDUSTRY<br>Construction  |  |
| 13a. STATE<br>Maryland   |  |                  |  | 13b. COUNTY<br>---  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                         | 13e. STREET ADDRESS<br>506 South Pulaski St. 21223   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Martin Homer Miller   |  |                  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Sarah Riggelman   |  |  |                         |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>No   |  |                  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>232-60-8276   |  | 17. INFORMANT ADDRESS<br>Joseph Miller 6092 Falls Road 21212  |  |  |                         |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Smoke and Soot Inhalation</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |                  |  |   |  |   |  |  |                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |  |                  |  |   |  |   |  |  |                         |  |  |
| 19a. DATE OF OPERATION   |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |  |                         | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>1:46pm 11/30 19 84  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br>subject in housefire |  |  |                         |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>home   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br>506 S. Pulaski St., Balto. City, Md.                |  |  |                         |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |  |   |  |   |  |  |                         |  |  |
| ACTUAL SIGNATURE<br>   |  |                  |  |   |  | TITLE (SPECIFY)<br>M.D. Assistant   |  |  | DATE SIGNED<br>11/30/84 |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Gregory R. Kauffman, M.D.   |  |                  |  |   |  | ADDRESS<br>111 Penn St.   |  |  |                         |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation   |  |                  |  | 23b. DATE<br>12-3-84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Memorial Park  |  |  |                         | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Westview, Balto. Co., Md.                       |  |
| 24. FUNERAL DIRECTOR NAME<br>Charles S. Zeiler & Son Inc.  |  |                  |  |   |  | ADDRESS<br>901 S. Conkling St.  |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 4 1984  |                         | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall                                       |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. GIVE PAGE 6 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25MBP  
DHMH 17  
(VR A15 ME (5))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 30104

FOR  
1- STATE  
REGISTRAR

|  |                  |  |   |   |  |
|--|------------------|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><del>XXXXXX</del> Sheri Rebecca Miller   |                  |  | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br>11/ 30/ 1984                                       |   | 2b. HOUR<br>M<br>A                           |
| 3. SEX<br>Female   | 4. RACE<br>White | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 24 84  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br>- 3 6                               | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>11/30/ 1984   | 7d. HOUR<br>M<br>A<br>2:00                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>506 S. Pulaski St. |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Infant                               |  |
| 13a. STATE<br>Maryland   |                  | 13b. CITY OR TOWN<br>Baltimore   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS<br>506 South Pulaski St. 21223  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Richard Sloan Miller Sr.   |                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Barbara Faye James                             |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |                  | 16b. SOCIAL SECURITY NO.<br>None   |   | 17. INFORMANT ADDRESS<br>Jacob F. James 740 E. 30th. St. 21218  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Smoke and Soot Inhalation<br>8902<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |                  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                  |  |   |   |  |
| 19a. DATE OF OPERATION   |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>1:46xx 11/30/ 84  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>subject in housefire |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>   |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>home  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>506 S. Pulaski St., Balto. City, Md.             |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                  |  |   |   |  |
| ACTUAL SIGNATURE<br>Gregory R. Kauffman, M.D.  |                  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER   |   | DATE SIGNED<br>11/30/84   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |                  | ADDRESS<br>111 Penn St.  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation  |                  | 23b. DATE<br>12-3-84   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Memorial Park  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Charles S. Zeiler & Son Inc.   |                  | ADDRESS<br>901 S. Conkling St.   |   | 25a. DATE REC'D. BY REGISTRAR<br>DEC 4 1984   |  |
|  |                  |  |   | 25b. REGISTRAR'S SIGNATURE<br>Lelia Davidson-Penderson  |  |



James F. Miller

James F. Miller - 12-21-19

U.S.A.

James

James F. Miller - 12-21-19

James F. Miller - 12-21-19

James F. Miller - 12-21-19

12-21-19

James F. Miller - 12-21-19

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |   |  |
|--|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | 2a. DATE OF DEATH  |   | 2b. HOUR  |  |
| SIMON MILLER   |  | NOVEMBER 23, 1984  |   | 4:25 A.M.   |  |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | 7. UNDER 1 YEAR   |  |
| Male   | White  | July 1, 1934   | 50  | MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |   |  |
| New York   | U. S. A.   |  | BALTIMORE CITY MD.  |   |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |   | 12b. KIND OF BUSINESS OR INDUSTRY            |
| BALTIMORE  | JOHNS HOPKINS HOSPITAL   |  | Owner   |   | Millers Garage                               |
| 13a. STATE   | 13b. COUNTY  | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS / ZIP CODE                                      |  |
| Maryland   | Prince Georges   | Laurel   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 7614 Erica Lane 20707   |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |   | 16. ADDRESS   |  |
| Louis Miller   |  | Bessie Cohen   |   |   |  |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  | 17b. SOCIAL SECURITY NO.   | 17. INFORMANT  |   |   |  |
| yes  | Korean   | Sandra L. Miller (Same as # 13)  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST   |  |  |   |   | 15 MINUTES                                   |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |   |   | 2 MONTHS                                     |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |   |   | 3 WEEKS                                      |
| (b) ACUTE LYMPHOCYTIC LEUKEMIA   |  |  |   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |   |   |  |
| (c) PROBABLE SEPSIS  |  |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a   |  |  |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?   |  |
| —  |  | —  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)       |   |   |  |
| YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21b. TIME OF INJURY  |   |   |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |   |   |  |
|  |  | P.M. 19  |   |   |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION   |  |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | —  |   | CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that this hospital attended the deceased from 22 SEPTEMBER 84 to 23 NOVEMBER 19 84, that we last saw the deceased alive on 23 NOVEMBER 19 84, and that in my opinion death occurred on the date and hour and from the causes stated above. (We will not view the body after death.) |  |  |   |   |  |
| 22b. SIGNATURE   |  | DEGREE   |   | 22c. DATE SIGNED  |  |
| KAREN SZAUTER  |  | NO   |   | 23 NOV 84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |   | 22f. DATE SIGNED BY REGISTRAR                                       |  |
| KAREN SZAUTER  |  | JOHNS HOPKINS HOSPITAL   |   | 23 NOV 84   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY                                  |  |
| Burial   |  | 11/25/1984   |   | Judean Memorial Gardens   |  |
| 23d. LOCATION  |  | 23e. COUNTY  |   | 23f. STATE  |  |
| Olney, Montgomery, Md.   |  | COUNTY   |   | STATE   |  |
| 24. FUNERAL DIRECTOR   |  |  |   |   |  |
| DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME   |  |  |   |   |  |
| 232 CARROLL STREET, N. W., WASHINGTON, D. C. NOV 28 1984   |  |  |   |   |  |

SP FT SIS  
JOHN BRIDGES  
P. 10/10/10

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |   |   |   |  |   |  |   |  |
|---|--|---|---|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>GERALD Edward Milligan</b>   |  |   | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>14</b> YEAR <b>84</b> |   |  | 2b. HOUR<br><b>12 10</b> <sup>A</sup> <sub>M</sub>  |  |   |  |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>B</b>   |   | 5. DATE OF BIRTH<br>MONTH <b>5</b> DAY <b>3</b> YEAR <b>47</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>37</b> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Lutheran Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY                                       |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1143 N. Stockton St. 21217</b>                |  |
| 14. FATHER'S NAME<br>FIRST <b>James</b> MIDDLE <b>Milligan</b> LAST <b>Conway</b>                           |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Ada</b> MIDDLE <b>Conway</b> LAST <b>Conway</b>  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>Yes</b> (IF YES, GIVE WAR OR DATES) |  |   |   | 16b. SOCIAL SECURITY NO.<br><b>212-48-2759</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>James Milligan 4504 Penhurst Avenue</b>                          |  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF,

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost.

**Respiratory failure - shock**

(b) **Pancreatitis + sepsis**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/9</b> , 19 <b>84</b> , to <b>11/13</b> , 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>11/14</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Blair T Duong</b>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/14/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BLAIR T DUONG</b>  |  |  |  | 22e. ADDRESS<br><b>LUTHERAN HOSPITAL</b>   |  |   |  |

|  |  |                              |  |  |  |   |  |
|--|--|------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b> |  | 23b. DATE<br><b>11/17/84</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn Cem.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD</b> |  |
|--|--|------------------------------|--|--|--|---|--|

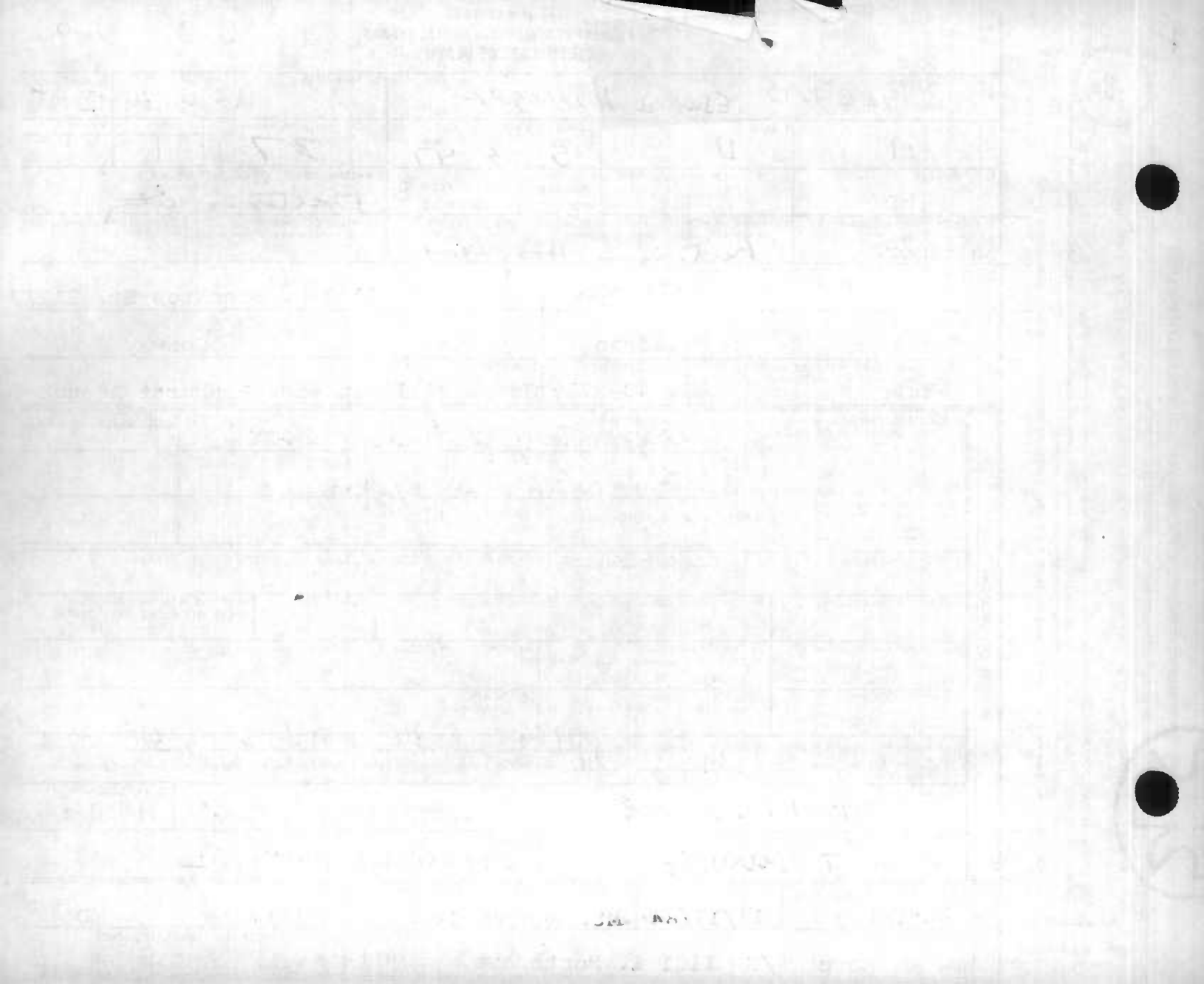
|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H 1101 E. North Ave.</b> |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 16 1984</b> |  | 25b. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i> |  |
|--|--|---|--|--|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |   |   |  |  |   |
|--|---|---|--|--|---|
| FOR<br>1- STATE REGISTRAR  |   | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  | 8430107  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>RUTH M. MILLS  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>NOVEMBER 12, 1984                     |  | 2b. HOUR P<br>6:18 M  |
| 3. SEX<br>FEMALE   | 4. RACE<br>CAUC.  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>07 18 1922  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>62 YRS                                    |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>VIRGINIA   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                   |  |   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>ASSEMBLY |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>EDGEWOOD ARS.  |
| 13a. STATE<br>MARYLAND   |   |   | 13b. COUNTY<br>BALTIMORE   | 13c. CITY OR TOWN<br>BALTIMORE   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>1eo - THURMAN  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>HALLIE R. MOONEY            |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO   |   | 16b. SOCIAL SECURITY NO.<br>228-12-3010   | 17. INFORMANT<br>ADDRESS<br>Mr. ANDREW S. MILLS - 219 N. Castle St. 21231    |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Asystole</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Metabolic acidosis, ammoniemia 1 day</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>liver failure</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>5 min</u><br><u>2-3 yrs</u> |   |   |  |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>Panophthemia with hypersplenism</u>  |   |   |  |  |   |
| 19a. DATE OF OPERATION<br>NA   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>NA  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/11/84</u> to <u>11/12/84</u> , that (I) (we) last saw the deceased alive on <u>11/12/84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |   |   |  |  |   |
| 22b. SIGNATURE<br><u>Stuart R Fritz</u>  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |  | 22c. DATE SIGNED<br>11/12/84   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>STUART R FRITZ  |   | 22e. ADDRESS<br>Johns Hopkins Hospital, Balt, MD  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |   | 23b. DATE<br>11/15/84   | 23c. NAME OF CEMETERY OR CREMATORY<br>Oak Lawn                               |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md.                                    |
| 24. FUNERAL DIRECTOR<br>NAME<br>Walter Dabrowski - 1005 Dundalk Ave. 21224   |   | 25a. DATE OF DEATH<br>NOV 19 1984   |  |  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Pages 1 and 2 should be filed within 72 hours after death. TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

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Handwritten scribble or signature in the top left corner.

Very faint, illegible text spanning the upper middle section of the page, possibly bleed-through from the reverse side.

Large area of extremely faint, illegible text covering the lower half of the page, likely bleed-through from the reverse side.

Faint text at the bottom of the page, including what appears to be a date or reference number on the left and some illegible text on the right.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examination must be certified by one.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

|   |  |   |  |   |   |  |   |  |  |
|---|--|---|--|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MARY MITCHELL</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 19, 1984</b>                    |   |   | 2b. HOUR<br><b>11:50P</b>  |   |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 18 98</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b>   |   | 7. YRS. UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Hospital</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Housework</b>  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Stephen Fuchs</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Marie Slivka</b>  |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>219-26-9588</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Hannah Gaydos 3824 Fait Avenue 21224</b>   |   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line 1a, (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sepsis</b><br><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Malnutrition</b><br><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Arteriosclerotic cardiovascular Disease</b> |  |   |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><b>Diabetes Mellitus, Parkinson Disease</b>   |  |   |  |   |   |  |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                  |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)             |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |
| 22a. I certify that <b>this hospital</b> attended the deceased from <b>November 16, 1984</b> to <b>November 19, 1984</b> , that <b>we</b> saw the deceased alive on <b>November 19, 1984</b> , and that in <b>our</b> opinion death occurred on the date and hour and from the causes stated above. <b>we</b> will view the body after death.   |  |   |  |   |   |  |   |  |  |
| 22b. SIGNATURE<br><b>A. P. Nazemi M.D.</b>  |  |   | DEGREE<br><b>M.D.</b>  |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>11/19/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A.P. Nazemi M.D.</b>  |  |   | 22e. ADDRESS<br><b>Church Hospital<br/>100 North Broadway Baltimore, MD. 21231</b> |   |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>11-23-84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cem.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore City Md.</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Charles S. Zeiler &amp; Son Inc.</b>   |  |   | ADDRESS<br><b>901 S. Conkling St.</b>  |   |   | 25. DATE RECEIVED BY REGISTRAR<br><b>NOV 23 1984</b>   |   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called and a post-mortem examination required.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 4 3 0 1 0 9  |  |
|---|--|---|--|--|--|
| FOR<br>STATE<br>REGISTRAR   |  |   |  | CERTIFICATE OF DEATH   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  | 7a. DATE OF DEATH  |  |
| FIRST MIDDLE LAST<br>Martin George Moan   |  |   |  | MONTH DAY YEAR<br>11 15 84   |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH   |  |
| Male  |  | White   |  | MONTH DAY YEAR<br>1 2 12   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |
| Maryland  |  | U.S.A.  |  | 72 YRS.  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |
| Baltimore   |  | St. Agnes Hospital  |  | Baltimore City MD.   |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| Electrician   |  | Union   |  |  |  |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  |
| Maryland  |  | Baltimore   |  | Lansdowne  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  | 13d. INSIDE CITY LIMITS?   |  |
| George T. Moan  |  | Mary E. Schrevfer   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT ADDRESS  |  |
| NO  |  | 219-14-2406   |  | Stella C. Moan 3210 Janice Avenue 21227  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiovascular accident</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?  |  |
|   |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10-20</u> , 19 <u>84</u> , to <u>11-15</u> , 19 <u>84</u> , that (I) (we) lost<br>saw the deceased alive on <u>11-15</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |
| 22b. SIGNATURE<br><u>J. Williams</u><br>DEGREE <u>MD.</u>   |  |   |  | 22c. DATE SIGNED<br><u>11-15-84</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>KENNETH WILLIAMS</u>  |  |   |  | 22e. ADDRESS<br><u>SAH</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| Burial  |  | 11/19/84  |  | Holy Trinity Cemetery  |  |
| 23d. LOCATION<br>CITY OR TOWN   |  | 23e. COUNTY   |  | 23f. STATE   |  |
| Elkridge  |  | Howard  |  | Maryland   |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  |   |  | 25a. DATE REC'D. BY REGISTRAR  |  |
| Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>John Davidson-Randall</u>                     |  |
|   |  |   |  | NOV 20 1984  |  |

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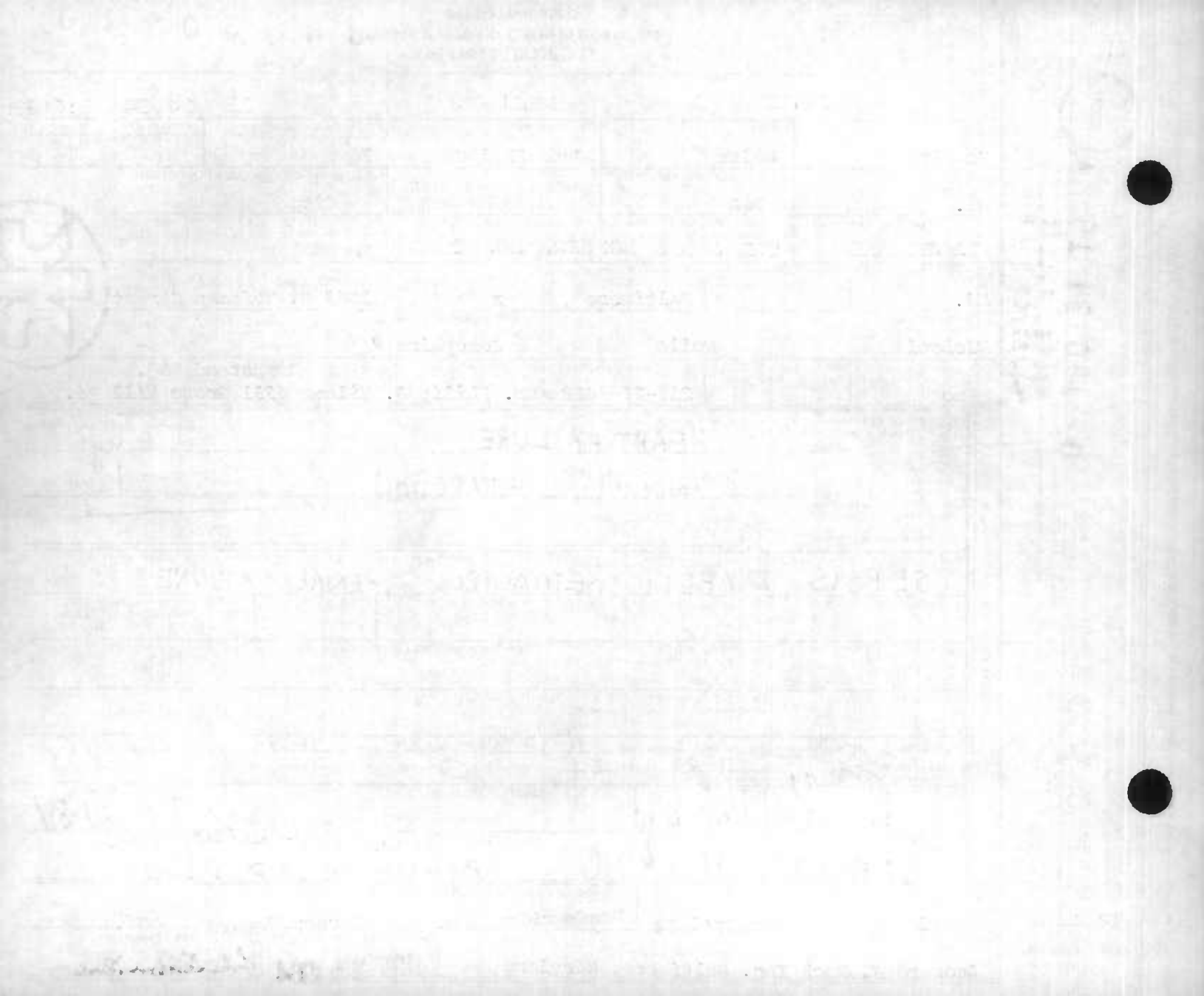




STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |                        |  |
|---|--|---|---|------------------------|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH   |   | 2b. HOUR               |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | 2a. DATE OF DEATH   |   | 2b. HOUR               |  |
| TILLIE B MOLLE  |  | 11 24 84  |   | 1:28 PM                |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)                               | 7. IF UNDER 1 YEAR     |  |
| Female  | White  | June 27, 1908   | 76  | MONTHS DAYS HOURS MIN. |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 9. CITIZEN OF WHAT COUNTRY?  | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 11. BALTIMORE CITY OR COUNTY OF DEATH                         |                        |  |
| Md.   | USA  |   | City MD.  |                        |  |
| 12. CITY OR TOWN OF DEATH   | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  | 15. KIND OF BUSINESS OR INDUSTRY                              |                        |  |
| BALTIMORE   | THE JOHNS HOPKINS HOSPITAL   | Homemaker   |   |                        |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   | 17. INSIDE CITY LIMITS?  | 18. STREET ADDRESS / ZIP CODE   | 19. ZIP CODE  |                        |  |
| Md.   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                    | 2048 E. Hoffman Street  | 21213   |                        |  |
| 20. FATHER'S NAME   | 21. MOTHER'S MAIDEN NAME   | 22. ADDRESS   |   |                        |  |
| Michael Molle   | Josephine  | Hampstead, Md.  |   |                        |  |
| 23. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  | 24. SOCIAL SECURITY NO.  | 25. INFORMANT   |   |                        |  |
| no  | 215-28-9488  | Mr. Philip J. Wilson 4331 Gross Mill Rd.  |   |                        |  |
| 26. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:   |  |   |   |                        | 27. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) HEART FAILURE   |  |   |   |                        | 6 days   |
| DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION  |  |   |   |                        | 7 days   |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |   |   |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: SEPSIS, DIABETIC KETOACIDOSIS, RENAL FAILURE   |  |   |   |                        |  |
| 28. DATE OF OPERATION   | 29. CONDITION FOR WHICH OPERATION WAS PERFORMED  | 30. AUTOPSY?  | 31. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                        |  |
|   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  | YES <input type="checkbox"/> NO <input type="checkbox"/>      |                        |  |
| 32. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  | 33. TIME OF INJURY   | 34. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |                        |  |
|   | HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   |   |                        |  |
| 35. INJURY OCCURRED   | 36. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                     | 37. LOCATION  |   |                        |  |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | STREET CITY OR TOWN COUNTY STATE  |   |                        |  |
| 38. I certify that (I) (this hospital) attended the deceased from 11-12-84, 19-84, to 11-24, 19-84, that (I) (we) last saw the deceased alive on 11-24, 19-84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |   |                        |  |
| 39. SIGNATURE   | 40. DEGREE   | 41. MEDICAL ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>    |   | 42. DATE SIGNED        |  |
| Kenneth J. Holroyd  |  |   |   | 11-24-84               |  |
| 43. PHYSICIAN'S NAME (TYPE OR PRINT)  | 44. ADDRESS  | 45. BALTIMORE MD 21218  |   |                        |  |
| KENNETH HOLROYD   |  |   |   |                        |  |
| 46. BURIAL, CREMATION, REMOVAL (SPECIFY)  | 47. DATE   | 48. NAME OF CEMETERY OR CREMATORY   | 49. LOCATION  |                        |  |
| Burial  | Nov. 27, 1984  | Meadowridge Mem.  | Dorsey Howard Md.   |                        |  |
| 50. FUNERAL DIRECTOR  | 51. DATE REC'D. BY REGISTRAR   | 52. REGISTRAR'S SIGNATURE   |   |                        |  |
| Leonard J. Ruck Inc. Baltimore, Maryland  | NOV 26 1984  | Julia Davidson  |   |                        |  |



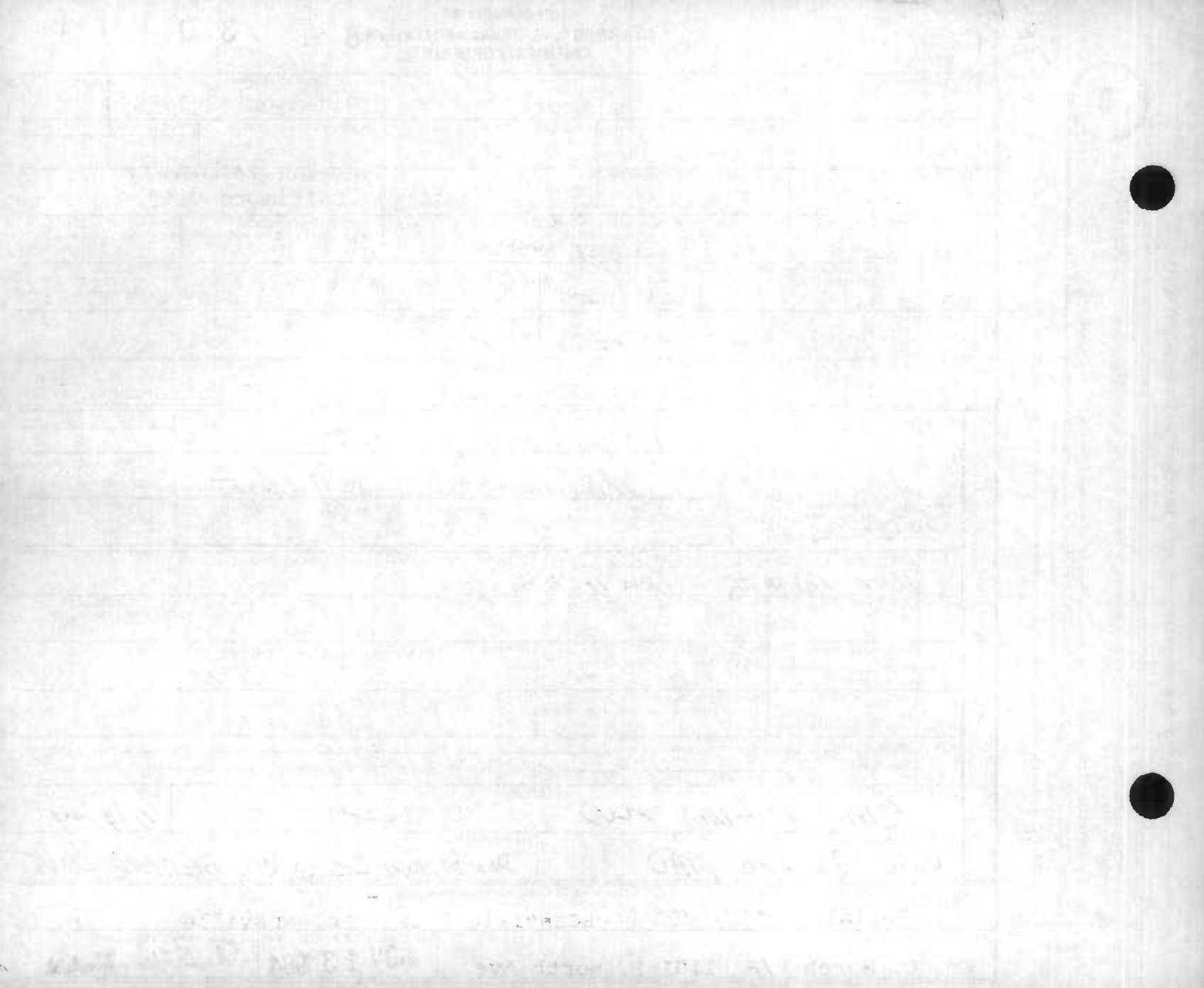
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |                                     |   |  | 3 4 3 0 1 1 1   |  |
|---|-------------------------------------|---|--|---|--|
| 1. FOR STATE REGISTRAR  |                                     |   |  | REG. NO.  |  |
| I. DECEASED NAME<br>(TYPE OR PRINT)<br>Callie W. Moore  |                                     |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 8, 1984        |   | 2b. HOUR<br>M  |
| 3. SEX<br>female  | 4. RACE<br>Black                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 15 1941   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>43 YRS   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N.C.   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3915 Calloway Avenue                           |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  |
| 13a. STATE<br>MD  |                                     | 13b. COUNTY   | 13c. CITY OR TOWN<br>Baltimore                                 | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>David Matier  |                                     | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Callie Rudd  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) No   |                                     | 16b. SOCIAL SECURITY NO.<br>240-64-3756   | 17. INFORMANT ADDRESS<br>Angelia Heughan 3915 Calloway Apt 100 |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>METASTATIC CARCINOMA OF BREAST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |                                     |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br><u>BRAIN METASTASIS, (LIVER METASTASIS)</u>  |                                     |   |  |   |  |
| 19a. DATE OF OPERATION  |                                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF INJURY, NOTIFY MEDICAL EXAMINER)  |                                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |                                     | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |                                     |   |  |   |  |
| 22b. SIGNATURE<br><u>Paul Celano MD</u>   |                                     |   |  | 22c. DATE SIGNED<br>11/9/84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>PAUL CELANO, MD  |                                     |   |  | 22e. ADDRESS<br>John Hopkins Oncology CTR, BALTIMORE 21205                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |                                     | 23b. DATE<br>11/13/84   | 23c. NAME OF CEMETERY OR CREMATORY<br>McLeansville Bapt        |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>McLeansville N. C.   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H  |                                     |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 13 1984                   |   | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |

BP \_\_\_\_\_



STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH   |  | MONTH DAY YEAR   |  | 2b. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST MIDDLE LAST   |  | 11 9 84  |  | 0650 A.M.   |  |
| JAMES REGINALD MOORE, JR   |  |   |  |  |  |   |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |
| Male   |  | White   |  | MONTH DAY YEAR   |  | 64 YRS.   |  |
| 11 25 20   |  |   |  |  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |
| Maryland   |  | U.S.A.  |  |  |  | Baltimore City MD.  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| Baltimore  |  | St. Agnes Hospital  |  | Machinist  |  | Westinghouse  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b. STATE  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  |
| Maryland   |  | A.A.  |  | Linthicum  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 13e. STREET ADDRESS / ZIP CODE   |  | 13f. STREET ADDRESS / ZIP CODE                                      |  | 13g. STREET ADDRESS / ZIP CODE   |  | 13h. STREET ADDRESS / ZIP CODE                                      |  |
| 319 Cheddington Road 21090   |  | 319 Cheddington Road 21090  |  | 319 Cheddington Road 21090   |  | 319 Cheddington Road 21090  |  |
| FATHER'S NAME  |  | MOTHER'S MAIDEN NAME  |  | 15. MOTHER'S MAIDEN NAME   |  | 15. MOTHER'S MAIDEN NAME  |  |
| FIRST MIDDLE LAST  |  | FIRST MIDDLE LAST   |  | FIRST MIDDLE LAST  |  | FIRST MIDDLE LAST   |  |
| GARY W. MOORE  |  | REITA PHILLIPS  |  | REITA PHILLIPS   |  | REITA PHILLIPS  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT  |  | ADDRESS   |  |
| Yes  |  | WW II   |  | 160-18-1679  |  | Md 21225  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  | PART I. DEATH WAS CAUSED BY:  |  | IMMEDIATE CAUSE (a)  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |
|  |  |   |  | Adenocarcinoma prostate  |  | 7 yrs   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  | DUE TO, OR AS A CONSEQUENCE OF (b)                                  |  | DUE TO, OR AS A CONSEQUENCE OF (c)   |  |   |  |
|  |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |   |  | Thrombocytopenia with subdural hematoma  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
|  |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)   |  |   |  |
|  |  | HOUR A.M. MONTH DAY YEAR  |  | LOST BALANCE IN HOME BATHROOM AND FELL BACKWARDS   |  |   |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION  |  | CITY OR TOWN STATE  |  |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK   |  | HOME  |  | 319 CHEDDINGTON RD, BALTO, MD. 21090   |  |   |  |
| 22a. I certify that (1) this hospital attended the deceased from 11-4-84 to 11-9-84, that (1) the deceased saw the deceased alive on 11-9-84, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE  |  | DEGREE   |  | 22c. DATE SIGNED  |  |
|  |  | Laurence R. Gallagher, M.D.   |  | M.D.   |  | 11-9-84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |  | 22f. ADDRESS   |  | 22g. ADDRESS  |  |
| LAURENCE R. GALLAGHER, M.D.  |  | ST AGNES MED. CTR, WILKENS  |  | + PINE HTS, BALTO, MD 21229  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  |
| Burial   |  | 11/12/84  |  | Meadowridge Mem Pk   |  | Dorsey Howard MA  |  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR                                       |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |
| George J. Gonce 4001 Ritchie Hwy Balto Md  |  | NOV 14 1984   |  | Julia Davidson-Randall   |  |   |  |

BP

10

George A. Jones 4500 Hillside Ave. Chicago, Ill.  
Dear Sir:  
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the above matter.  
The same has been forwarded to the proper authorities for their consideration.  
Very respectfully,  
J. H. Jones  
Secretary



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 4 3 0 1 1 3   |  |
|---|--|---|--|---|--|
| 1. REGISTRAR <b>Milton Leroy Moore Jr.</b>  |  |   |  | CERTIFICATE OF DEATH  |  |
| 1. DECEASED NAME  |  |   |  | 7a. DATE OF DEATH   |  |
| FIRST MIDDLE LAST<br><b>MILTON LEROY MOORE JR.</b>  |  |   |  | MONTH DAY YEAR<br><b>11 24 84</b>   |  |
| 2. SEX<br><b>MALE</b>   |  |   |  | 7b. HOUR<br><b>8:41 PM</b>  |  |
| 3. RACE<br><b>Caucasian</b>   |  |   |  | 8. AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b> YRS.   |  |
| 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 17 24</b>   |  |   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>   |  |
| 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Accountant</b>  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>   |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Chemical Co.</b>  |  |
| 9. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |   |  | 17. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SOUTH BALTIMORE General Hospital</b> |  |
| 11. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>  |  |   |  | 12c. STREET ADDRESS / ZIP CODE<br><b>APTC 104 GOVERNORS CT 21061</b>  |  |
| 13b. COUNTY<br><b>ANN ARUNDEL</b>   |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 13c. CITY OR TOWN<br><b>GLEN BORNIE</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>VIOLET MOORE</b>  |  |
| 16. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>MILTON MOORE</b>   |  |   |  | 17. INFORMANT<br><b>Balto 21225</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Yes</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>212-20-4721</b>  |  |
| 16c. ADDRESS<br><b>Robert K. Moore Sr. 5712 Redmond St.</b>   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Massive Pulmonary Embolus</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>post pneumoniae</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hr.</b><br><b>14 days</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>11/14/84</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Left Lung mass, Carcinoma</b>  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) |  |   |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |   |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/13</b> , 19 <b>84</b> , to <b>11/24</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>11/24</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Rosendo Martinez</b>   |  |   |  |   |  |
| 22c. DATE SIGNED<br><b>11/24/84</b>   |  |   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Rosendo Martinez</b>  |  |   |  |   |  |
| 22e. ADDRESS<br><b>South Baltimore General Hospital</b>   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11/28/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemety Brooklyn</b>   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>A.A. Md.</b>   |  | 24. FUNERAL DIRECTOR <b>Balto. Md. 21225</b><br>NAME ADDRESS<br><b>George J. Gonce 4001 Ritchie Hgwy.</b>   |  |   |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 27 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers Pages 1 and 2 and be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |  |   |  |  |  |  |  |  |  |                          |  |             |  |
|---|--|--|--|---|--|---|--|--|--|--|--|--|--|--------------------------|--|-------------|--|
| 1. FOR STATE REGISTRAR  |  |  |  | 8 4 3 0 1 1 4   |  |   |  |  |  |  |  |  |  |                          |  |             |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  | 2a. DATE OF DEATH   |  | MONTH   |  | DAY  |  | YEAR   |  | 2b. HOUR                                     |  |                          |  |             |  |
| RUTH PLUNKETT MOORE   |  |  |  | 11  |  | 22  |  | 84   |  | 10   |  | 50 A   |  |                          |  |             |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS.   |  |  |  |                          |  |             |  |
| Female  |  | White  |  | January 26, 1911  |  | 73 YRS.   |  | MONTHS   |  | DAYS   |  | HOURS MIN.                                   |  |                          |  |             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |  |  |  |  |                          |  |             |  |
| Virginia  |  | United States  |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    |  | Baltimore City MD.  |  |  |  |  |  |  |  |                          |  |             |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |                          |  |             |  |
| Baltimore   |  | Union Memorial Hospital  |  |   |  | Sales-Monumental  |  | Life Insurance   |  |  |  |  |  |                          |  |             |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS / ZIP CODE                                      |  |  |  |  |  |  |  |                          |  |             |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 21210  |  |  |  |  |  |                          |  |             |  |
| Maryland  |  |  |  | Baltimore   |  |   |  | 6110 Bellinham Road Court  |  |  |  |  |  |                          |  |             |  |
| 14. FATHER'S NAME   |  |  |  | 15. MOTHER'S MAIDEN NAME  |  |   |  |  |  |  |  |  |  |                          |  |             |  |
| Ernest  |  | Codell   |  | Plunkett  |  | Maude   |  | Cooke  |  | Plunkett   |  |  |  |                          |  |             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  |   |  | ADDRESS  |  |  |  |  |  |                          |  |             |  |
| No  |  | 217-07-0641  |  | Lawrence Heinzer  |  |   |  | 213 Midhurst Road-21212  |  |  |  |  |  |                          |  |             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |  |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                          |  |             |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |   |  |   |  |  |  |  |  |  |  |                          |  |             |  |
| IMMEDIATE CAUSE (a)   |  |  |  |   |  |   |  |  |  |  |  | CARDIO PULMONARY ARREST                      |  | Immed                    |  |             |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |  |   |  |  |  |  |  |  |  |                          |  |             |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |   |  |   |  |  |  |  |  | (b)  |  | Cerebrovascular Accident |  | 1 1/2 weeks |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |  |   |  |  |  |  |  | (c)  |  |                          |  |             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |  |  |  |  |  |  |  |                          |  |             |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                      |  |   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |  |                          |  |             |  |
|   |  |  |  |   |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |  |                          |  |             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |  |  |                          |  |             |  |
|   |  |  |  | HOUR A.M. MONTH DAY YEAR  |  |   |  |  |  |  |  |  |  |                          |  |             |  |
|   |  |  |  | P.M. 19   |  |   |  |  |  |  |  |  |  |                          |  |             |  |
| 21d. INJURY OCCURRED  |  |  |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)                    |  |   |  | 21f. LOCATION  |  |  |  |  |  |                          |  |             |  |
| WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>   |  |  |  |   |  |   |  | CITY OR TOWN COUNTY STATE  |  |  |  |  |  |                          |  |             |  |
| AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  |   |  |   |  |  |  |  |  |  |  |                          |  |             |  |
| 22a. I certify that (I (this hospital) attended the deceased from Nov 10, 19 84, to Nov 22, 19 84, that (I (we) last saw the deceased alive on Nov 22, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death. |  |  |  |   |  |   |  |  |  |  |  |  |  |                          |  |             |  |
| 22b. SIGNATURE  |  |  |  | DEGREE  |  |   |  | 22c. DATE SIGNED   |  |  |  |  |  |                          |  |             |  |
| Susan M. Yeomans  |  |  |  | MD  |  |   |  | 11/22/84   |  |  |  |  |  |                          |  |             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS  |  |   |  |  |  |  |  |  |  |                          |  |             |  |
| SUSAN M. YEOMANS, M.D.  |  |  |  | 201 E. UNIVERSITY PKWY. BALTIMORE, MD 21218   |  |   |  |  |  |  |  |  |  |                          |  |             |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY                                  |  | 23d. LOCATION  |  | COUNTY STATE   |  |  |  |                          |  |             |  |
| Cremation   |  |  |  | November 23, 1984   |  | Greenmount  |  | Baltimore, Maryland  |  |  |  |  |  |                          |  |             |  |
| 24. FUNERAL DIRECTOR  |  |  |  | 25a. DATE REC'D. BY REGISTRAR   |  |   |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |                          |  |             |  |
| NAME  |  |  |  | ADDRESS   |  |   |  |  |  |  |  |  |  |                          |  |             |  |
| Mitchell-Wiedefeld Home   |  |  |  | 6500 York Road  |  |   |  | NOV 25 1984  |  |  |  |  |  |                          |  |             |  |

It's all about

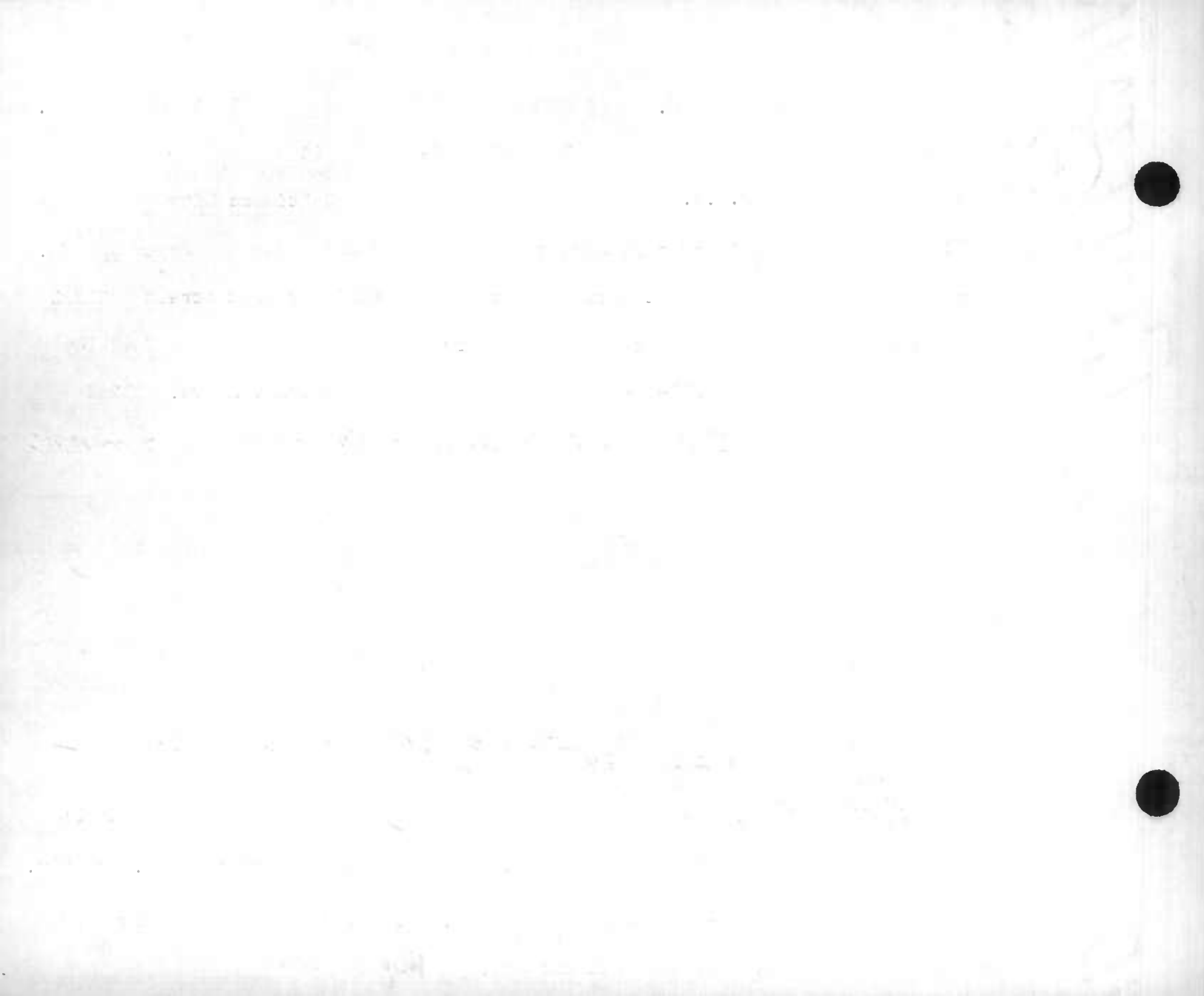
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and signed.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |   |  |   |   |   |  | REG. NO.  |  |
|--|--|--|---|---|--|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>WILLIAM H. MOORE</b>   |  |  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 2 84</b>  |   |   | 2b. HOUR<br><b>1:00P</b>  |  |   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 27 39</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>45</b> YRS.   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS   |  | 8. IF UNDER 24 HRS<br>HOURS MIN.                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |   |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1322 Sargeant Street</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Machinist</b>            |   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Paper Bag Co.</b>  |   |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br><b>1322 Sargeant Street 21223</b>           |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frank Moore</b>   |  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Teeheley</b>  |   |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>213-34-1758</b>   |   | 17. INFORMANT ADDRESS<br><b>Ruth Healey 1708 Rockhaven Ave. 21228</b>   |  |   |   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Small Cell Carcinoma of the Lung</b>   |  |  |   |   |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 months</b> |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |   |   |  |   |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |   |  |   |   |   |  |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                        |   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>5:45 11 19 84</b> |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 26 19 84</b> to <b>Nov 2 19 84</b> , that (I) (we) lost<br>saw the deceased alive on <b>Oct 26 19 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |  |   |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Paul Gormley</b>  |  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   |   |  | 22c. DATE SIGNED<br><b>11/2/84</b>                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Paul Gormley</b>   |  |  |   |   | 22e. ADDRESS<br><b>St. Agnes Hospital Oncology Dept. 3rd Flr.</b>  |   |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>11-05-84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge Mem. Pk.</b>  |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Elkridge Howard Maryland</b> |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Hubbard Funeral Home, Inc.</b>  |  |  |   |   | ADDRESS<br><b>4107 Wilkens Ave.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 5 1984</b>                        |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |   |  |

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |   |   |  |   |  |  |  |
|---|--|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE AND PRINT)<br>Rev. John Frank Mooring   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11-19-84 |   |  | 2b. HOUR<br>3:20 PM   |  |  |  |
| 3. SEX<br>M   |  | 4. RACE<br>B   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 9 18   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>66 YRS.  |  |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN)<br>North Car.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Balto  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Lutheran Hospital |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Md.   |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br>Balto  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>21207<br>4806 Gwynn Oak Ave   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George Mooring Jr   |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Carrie E   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>241-32-7211   |   | 17. INFORMANT<br>FAIRELLA MOORING   |  |   |  | ADDRESS<br>4806 Gwynn Oak Ave.   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of the stomach.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><u>metastasis to the liver.</u> |  |  |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11-17-</u> 19 <u>84</u> , to <u>11-19-</u> 19 <u>84</u> , that (I) (we) lost<br>saw the deceased alive on <u>11-19-</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br>A. Mathew   |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br>11-19-84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>A. Mathew  |  |  |   | 22e. ADDRESS<br>Lutheran Hospital 730 Ashburton St.<br>Baltimore  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>11/26/84  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>King Mem. Park  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Md.  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leroy O. Dyett  |  |  |   | ADDRESS<br>4600 Liberty Hqts. Ave   |  | 25a. DATE REGD. BY REGISTRAR<br>NOV 23 1984   |  | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randall  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



Rev John Frank Thompson  
11 P M  
Baltimore  
Md  
Gaines  
241 St John Church  
Baltimore Md



CHIEF

20% COOL RAIN

General  
Baltimore Md



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |  |   |  |  |  | REG. NO. 84 30117 |  |
|---|--|--|--|---|--|---|--|--|--|-------------------|--|
| 1- FOR STATE REGISTRAR  |  |  |  |   |  |   |  |  |  |                   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Gracie Morgan  |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>11 3 84  |   |  | 2b. HOUR<br>11:59 A.M.   |  |                   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Black   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>4-7-1908   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS   |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN.   |  |                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore, City MD.                                     |  |  |  |                   |  |
| 10. CITY OR TOWN OF DEATH<br>Balto.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Provident Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired                        |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Balto.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>2121 Windsor Garden Lane 21208   |  |                   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>George Rose  |  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Mildred Rose   |   |  |  |  |                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>no   |  | 16b. SOCIAL SECURITY NO.<br>226-66-5272  |  | 17. INFORMANT ADDRESS<br>Hazel Boyd 5514 Peerless Ave.  |  |   |  |  |  |                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardio Pulmonary Arrest<br>DUE TO, OR AS A CONSEQUENCE OF (b) Ventricular Dysrhythmia<br>DUE TO, OR AS A CONSEQUENCE OF (c) Cardiomyopathy<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 6  |  |  |  |   |  |   |  |  |  |                   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)  |  |   |  |  |  |                   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/3, 19 84, to 11/3, 19 84, that (I) (we) last saw the deceased alive on 11/3, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |                   |  |
| 22b. SIGNATURE<br>Eleanor Y. Hixon, MD  |  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  | 22c. DATE SIGNED<br>11/3/84  |  |                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Eleanor Y. Hixon, MD   |  |  |  |   | 22e. ADDRESS<br>Box 37 3100 Towanda Ave.   |   |  |  |  |                   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>11-6-84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Mem. Pk.  |  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Arbutus H.C. Maryland |  |  |                   |  |
| 24. FUNERAL DIRECTOR NAME<br>Chas. A. Rice FSPA 1300 Eutaw Pl.  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 5 1984  |   | 25b. REGISTRAR'S SIGNATURE<br>R. Davidson                        |  |  |                   |  |

BP

1000 1000 1000

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>CORINNE C. MORROW</b>                             |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 12, 1984</b>                                 |  | 2b. HOUR<br><b>7:30A</b>                         |
| 3. SEX<br><b>FEMALE</b>   | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MAR. 1932</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>52</b> YRS  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>0 0 0 0</b>           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NEW YORK</b>                                | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN THIS FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>NONE</b>                 |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>NONE</b> |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |   |   |  |  |
| 13a. STATE<br><b>MARYLAND</b>   | 13b. COUNTY<br><b>BALTIMORE</b>  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>201 N. BROADWAY, APT. 7C #21231</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOSEPH LEVY</b>                                |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ESTELLE ROTHMAN</b>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>           |  | 16b. SOCIAL SECURITY NO.<br><b>130-26-6103</b>  | 17. INFORMANT <b>MR. CHARLES M. LEVY</b><br><b>5816 BROOKSIDE DR. CHEVY CHASE, MD 20815</b>     |  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a). **Pacemaker failure**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b) \_\_\_\_\_

DUE TO, OR AS A CONSEQUENCE OF

(c) \_\_\_\_\_

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

**Prosthetic aortic valve**

|  |   |  |   |
|--|---|--|---|
| 19a. DATE OF OPERATION<br><b>Nov 2 1984</b>  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Infected pacemaker</b> | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/29</b> 19 <b>84</b> to <b>11/12</b> 19 <b>84</b> , that (I) (we) last<br>saw the deceased alive on <b>Nov 12</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |   |  |   |
| 22b. SIGNATURE<br><b>David Ellison</b>   | DEGREE<br><b>MD</b>   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED<br><b>11/12/84</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DAVID ELLISON</b>  |   | 22e. ADDRESS<br><b>600 N. WOLFE BALTO., MD. 21205</b>  |   |

|  |                                   |   |   |
|--|-----------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>   | 23b. DATE<br><b>NOV. 15, 1984</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ANSHE EMUNAH-ATZ CHAIM</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b> |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>SOL LEVINSON &amp; BROS., INC.<br/>6010 REISTERSTOWN RD. BALTO., MD 21215</b> |                                   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 20 1984</b>                 | 25b. REGISTRAR'S SIGNATURE<br><b>na Davidson-Randall</b>                |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR  |  |  |  |  | REG. NO.   |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <i>Isobella</i>  |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <i>11 18 84</i>   |  |  |  |  |
| 3 SEX <i>FEMALE</i>   |  |  |  |  | 2b. HOUR <i>5:30 P.M.</i>  |  |  |  |  |
| 4 RACE <i>W</i>   |  |  |  |  | 5. DATE OF BIRTH MONTH DAY YEAR <i>8 08 1898</i>   |  |  |  |  |
| 6 AGE (IN YEARS LAST BIRTHDAY) <i>86</i>  |  |  |  |  | 7. IF UNDER 1 YEAR MONTHS DAYS   |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN) <i>Italy</i>  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>   |  |  |  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  |  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH <i>BALTIMORE City</i> MD.  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <i>Baltimore</i>  |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>LUTHERAN Hospital</i>    |  |  |  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>not employed</i>   |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <i>-</i>   |  |  |  |  |
| 13a. STATE <i>Maryland</i>  |  |  |  |  | 13b. CITY OR TOWN <i>Baltimore</i>   |  |  |  |  |
| 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  | 13d. STREET ADDRESS <i>2117 Denison St</i>   |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Anthony Monte</i>  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Margaret Pelegrini</i>   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>   |  |  |  |  | 16b. SOCIAL SECURITY NO. <i>213-10-8669</i>  |  |  |  |  |
| 17. INFORMANT ADDRESS <i>Mrs. R. Trionfo, 6 Echoway, 21204</i>  |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |  |  |  |  |  |  |  |  |
| PART 1. DEATH WAS CAUSED BY   |  |  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) <i>cardiac arrest</i>   |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>Ischemic heart disease</i>  |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>-</i>   |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>-</i>   |  |  |  |  |  |  |  |  |  |
| MEDICAL CERTIFICATION   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION <i>11/18/84</i>  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |  |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>11 18 84</i>   |  |  |  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)  |  |  |  |  | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                             |  |  |  |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11/18</i> 19 <i>84</i> , to <i>11/18</i> 19 <i>84</i> , that (I) (we) (did) (did not) view the deceased alive on <i>11/18</i> 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE <i>Gregory J. Lanpher</i> DEGREE <i>MD</i>   |  |  |  |  | 22c. DATE SIGNED <i>11/18/84</i>   |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Gregory J. Lanpher</i>   |  |  |  |  | 22e. ADDRESS <i>Lutheran Hospital</i>  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>   |  |  |  |  | 23b. DATE <i>11-20-84</i>  |  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <i>Holy Cross Cem.</i>   |  |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Brooklyn, A.A. City, Md.</i>  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME <i>CURRAN FUNERAL HOME, CAMBRIDGE, MD.</i>  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <i>NOV 26 1984</i>   |  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE <i>J. Davidson-Randall</i>   |  |  |  |  |  |  |  |  |  |

10

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

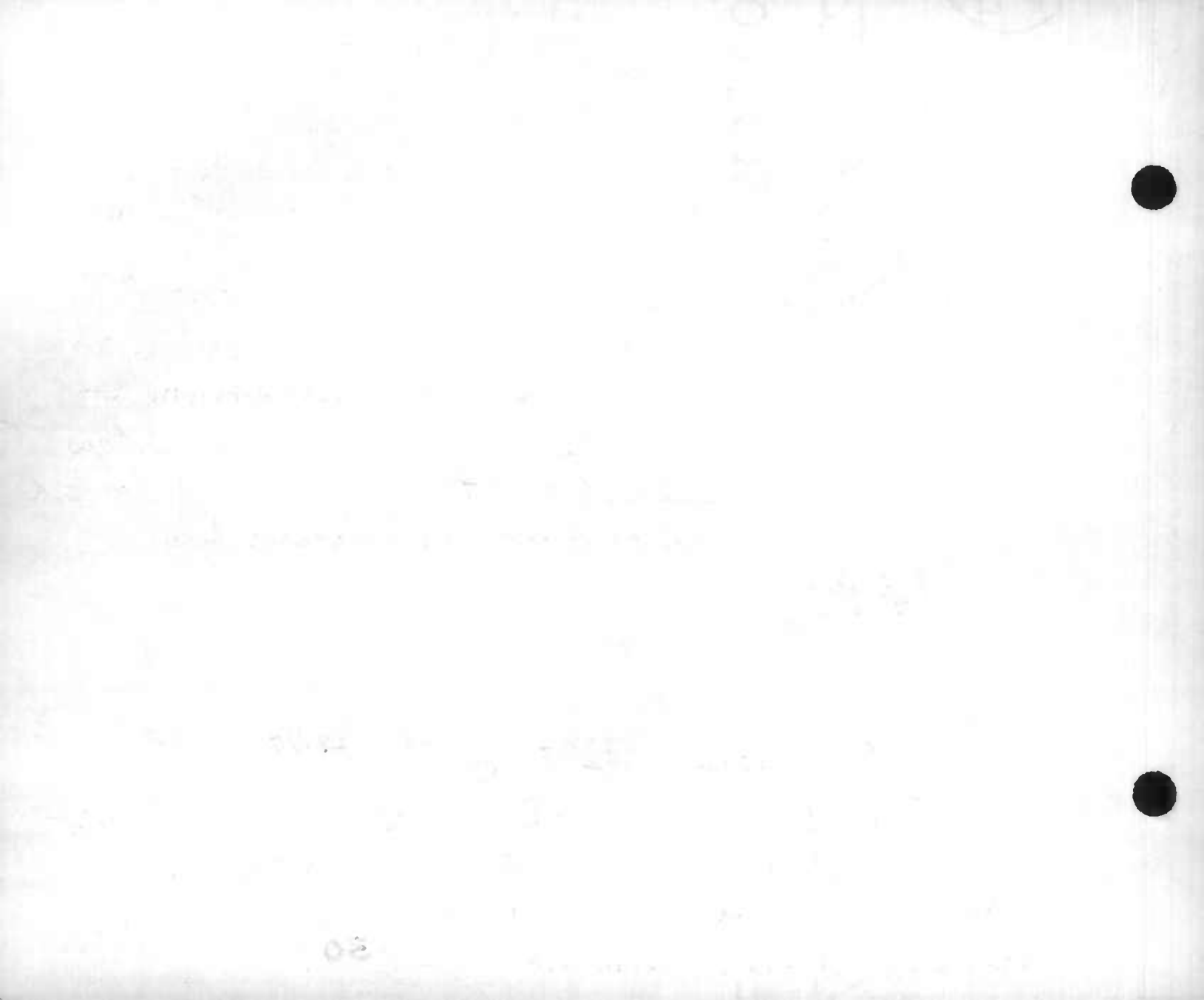
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REG. NO.

1 - FOR  
STATE  
REGISTRAR

|   |  |  |   |  |  |   |  |
|---|--|--|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>MARGARET S. MOSLEY  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 28 84 |  |  | 2b. HOUR<br>1055 AM   |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>BLACK   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 25 03   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>NO CAROLINA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BONSECOURS HOSPITAL |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |
| 13a. STATE<br>MD  |  | 13b. COUNTY<br>BALTO   |   | 13c. CITY OR TOWN<br>BALTO   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>PAT - SYKES   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>BERTHA - BREWINGTON   |   | 13e. STREET ADDRESS / ZIP CODE<br>2227 W. FAYETTE ST 21223   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>219-30-9512   |   | 17. INFORMANT<br>ADDRESS<br>Bertha Ellis - 2227 W. Fayette St  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Bilateral CVA</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerotic cerebral vasculature</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>Hypertension</u> |  |  |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>3 days<br>1 month |
| 19a. DATE OF OPERATION<br>None  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from 12 Oct 1984, to 28 Nov 1984, that (1) (we) lost<br>saw the deceased alive on 27 Nov 1984, and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above, (1) (we) (did) (did not) view the body after death.  |  |  |   |  |  |   |  |
| 22b. SIGNATURE<br>C. Coulter  |  | 22c. DATE SIGNED<br>11/28/84   |   | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |   |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Coulter  |  | 22f. ADDRESS<br>Bon Secours Hospital.  |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>12/1/84   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Ortobus Mem. Park  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Ortobus Md.   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Charles H. Powell   |  |  |   | 24b. ADDRESS<br>1206 W. North Ave  |  | 25a. DATE RECEIVED<br>NOV 30 1984   |  |





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#15, Film G598 12/3/84 kam

 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

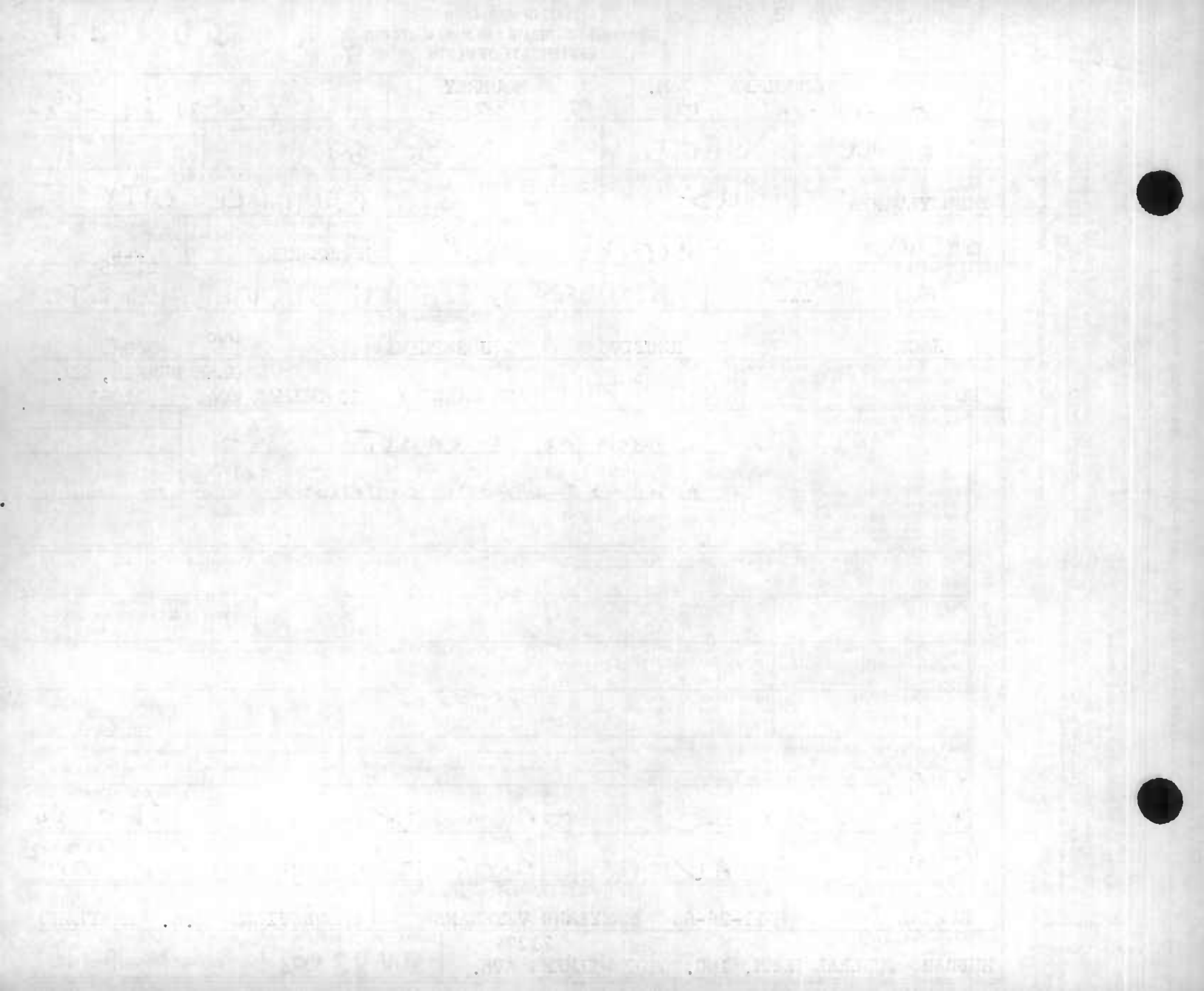
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1- STATE REGISTRAR

REG. NO.

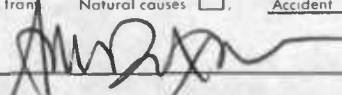
|   |  |   |  |
|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ANGELINA M. MOUBREY</b>  |  | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>21</b> YEAR <b>84</b> HOUR <b>3:06</b> AM   |  |
| 3. SEX<br><b>FEMALE</b>   | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br>MONTH <b>3</b> DAY <b>11</b> YEAR <b>25</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b> YRS.<br>IF UNDER 1 YEAR: MONTHS <b>0</b> DAYS <b>0</b><br>IF UNDER 24 HRS: HOURS <b>0</b> MIN. <b>0</b> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PENNSYLVANIA</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BON SECOURS HOSP</b>                           | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOMEMAKER</b>  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>21223</b>  |
| 13a. STATE<br><b>MD</b>   | 13b. COUNTY<br><b>BALTIMORE</b>  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |
| 14. FATHER'S NAME<br>FIRST <b>JACK</b> MIDDLE <b>RESTIVO</b> LAST <b>RESTIVO</b>  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>JOSEPHINE</b> MIDDLE <b>Duca</b> LAST <b>DOGA</b>   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b><br>(IF YES, GIVE WAR OR DATES)   |  |
| 16b. SOCIAL SECURITY NO.<br><b>218-18-5594</b>  |  | 17. INFORMANT<br><b>ANN MANCINI</b> ADDRESS <b>723 DELMAR ROAD GLEN BURNIE, MD. 21061</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>DISORDER</b>                            |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |   |  |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                           |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |
| 22b. SIGNATURE<br><b>John Shavers</b>   | DEGREE <b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br><b>11/21/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOHN SHAVERS</b>  | 22e. ADDRESS<br><b>6105 DAYLAND DR. BALT. MD</b>   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  | 23b. DATE<br><b>11-26-84</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MARYLAND VETERANS</b>  | 23d. LOCATION<br>CITY OR TOWN <b>CROWNSVILLE</b> COUNTY <b>A.A.</b> STATE <b>MARYLAND</b>  |
| 24. FUNERAL DIRECTOR<br>NAME <b>HUBBARD FUNERAL HOME, INC.</b> ADDRESS <b>4107 WILKENS AVE.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 23 1984</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

30122  
REG. NO.

|   |  |                      |  |   |  |  |  |  |  |   |  |   |  |
|---|--|----------------------|--|---|--|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>PASCALE MOURRAIN</b>   |  |                      |  |   |  |  |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>11 10 19 84</b> |  | 2b. HOUR <b>5:46 PM</b>   |  |
| 3. SEX <b>Female</b>  |  | 4. RACE <b>White</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>4 17 59</b>   |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) YRS. <b>25</b>                |  | 7. IF UNDER 1 YR. MONTHS DAYS  |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>11 10 19 84</b>                                 |  | 7d. HOUR <b>5:46 PM</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>France</b>   |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hospital (STU)</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING REE) <b>Technician</b>   |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Microbio Inc.</b>  |  |
| 13a. STATE <b>Md.</b>   |  |                      |  | 13b. CITY OR TOWN <b>Montgomery</b>   |  |  |  | 13c. CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  | 13d. STREET ADDRESS <b>3 Guy Ct. Md. 20850</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Andre Mourrain</b>  |  |                      |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Paule Tromeur</b> |  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>No</b>   |  |                      |  | 16b. SOCIAL SECURITY NO.  |  |  |  | 17. INFORMANT <b>Andre Mourrain</b>  |  |   |  | ADDRESS <b>8265 Lark Brown Rd. 21227</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>8447</b> IMMEDIATE CAUSE (a) <b>Thoraco-abdominal trauma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |                      |  |   |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1  |  |                      |  |   |  |  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |  |  |   |  | 20. AUTOPSY?<br><b>HEAD ONLY</b><br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                      |  | 21b. TIME OF INJURY<br>HOUR MONTH DAY YEAR <b>4 11-10-19 84</b>   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Parachutist blown into trees.</b>                                       |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>Ridgely Caroline Md.</b>   |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                      |  |   |  |  |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE   |  |                      |  | TITLE (SPECIFY) <b>Assistant</b>  |  |  |  | DATE SIGNED <b>11-11-84</b>  |  |   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>   |  |                      |  | ADDRESS <b>111 Penn St., Balto., Md. 21201</b>  |  |  |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>  |  |                      |  | 23b. DATE <b>11-15-84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Security Pro. Inc.</b>       |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Catonsville Md.</b>                          |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>MacNabb F.H. catonsville Md. 21228</b>   |  |                      |  |   |  | 25a. DATE REC'D BY REGISTRAR <b>NOV 16 1984</b>                    |  |  |  |   |  |   |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

#5, Film G598 12/10/84 kam

1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4

3 0 1 2 3

REG. NO.

|   |  |   |  |   |                                       |  |  |
|---|--|---|--|---|---------------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>WOODROW W. MULLEN</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 30 84</b> |   | 2b. HOUR<br><b>11:35A<sub>M</sub></b> |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>02 05 84</b>   |                                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>309 S. GILMOR STREET, 21223</b> |  |   |                                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>TRUCK DRIVER</b>                                    |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>SELF-EMPLOYED</b>   |  |   |  |   |                                       |  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>---</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |                                       | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 13e. STREET ADDRESS / ZIP CODE<br><b>309 S. GILMOR STREET, 21223</b>  |  |   |  |   |                                       |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN MULLEN</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>BURMATHEW UNKNOWN</b>   |  |   |                                       |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>225-01-5138</b>  |  | 17. INFORMANT<br><b>MARY B. MULLEN</b> ADDRESS<br><b>309 S. GILMOR STREET, 21223</b>  |                                       |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe COPD</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cardiac insufficiency</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>immediate</u><br><u>years</u><br><u>years.</u> |  |   |  |   |                                       |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><u>unknown -</u>  |  |   |  |   |                                       |  |  |
| 19a. DATE OF OPERATION<br><b>N/A.</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>N/A</b>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> N/A<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>N/A</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>N/A</b>  |                                       |  |  |
| 21d. INJURY OCCURRED<br>AT HOME <input type="checkbox"/> NOT HOME <input type="checkbox"/><br>AT WORK <input type="checkbox"/> NOT WORK <input type="checkbox"/><br><b>DR Ramos</b>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>N/A</b>  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>N/A</b>   |                                       |  |  |
| 22a. I certify that the hospital attended the deceased from <u>1976</u> , 19____, to <u>1984</u> , 19____, that (he) (she) lost<br>saw the deceased alive on <u>October 31</u> , 19 <u>84</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above. <u>I/we</u> did not view the body after death.                                    |  |   |  |   |                                       |  |  |
| 22b. SIGNATURE<br><b>Gloria M.D. for DR. E. Ramos M.D.</b>  |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |                                       | 22c. DATE SIGNED<br><b>12/01/84.</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GLORIA DAMIEN, M.D.</b>   |  | 22e. ADDRESS<br><b>4000 ANNAPOLIS ROAD</b>  |  |   |                                       |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>12-03-84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CREST LAWN MEM. GAR.</b>   |                                       | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>MARRIOTTSTVILLE HOWARD MD.</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HUBBARD FUNERAL HOME, INC.</b>   |  | ADDRESS<br><b>4107 WILKENS AVE.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 3 1984</b>  |                                       | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson</b>   |  |

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*[Faint, illegible handwritten text and markings throughout the page, including a large 'X' in the center and various scribbles.]*



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

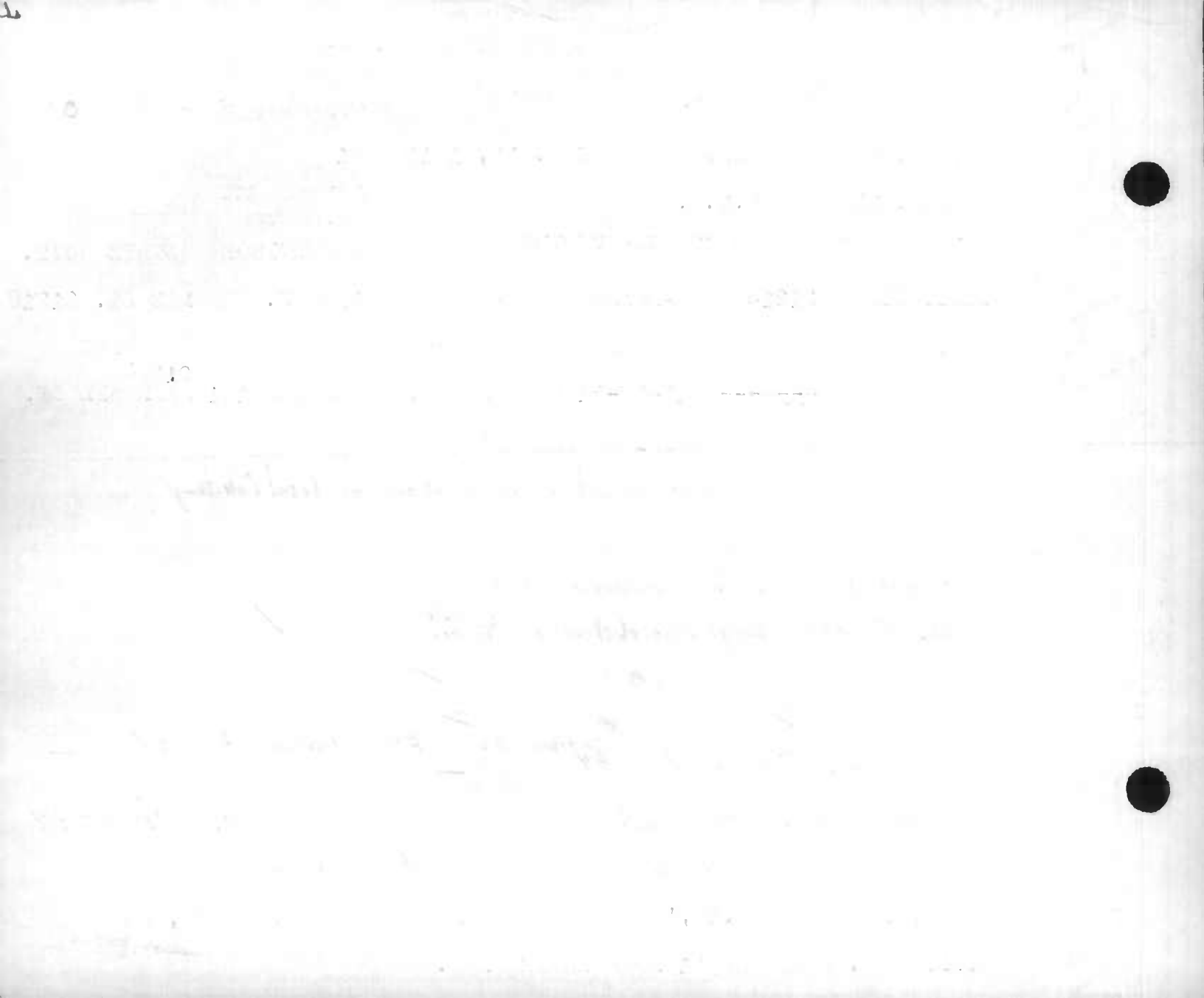
8 4 3 0 1 2 4

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |                              |  |  |
|---|--|---|---|---|------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>MARY E. MULLIN</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>November 8, 1984</b> |   | 2b. HOUR<br><b>2:10 A.M.</b> |  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>OCT. 23, 1913</b>   |                              | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN.<br><b>71</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE CITY</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>UNION MEMORIAL HOSPITAL</b>             |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SUPERVISOR</b>  |                              | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>STATE GOVT.</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>   |  |   |   | 13b. COUNTY<br><b>21218</b>   |                              | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>THOMAS MULLIN</b>   |  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>MARGUERITE POWERS</b>  |                              |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>213-20-3107</b>  |   | 17. INFORMANT ADDRESS<br><b>EVELYN A. DONHAUSER 8101 KIRK WALL CT. 21204</b>  |                              |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Post operative complications of Total Colectomy</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |   |                              |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Recent (D) Brain Cerebro vascular Accident</b>   |  |   |   |   |                              |  |  |
| 19a. DATE OF OPERATION<br><b>Nov. 5, 1984</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Large Bowel obstruction - 3 - colon tumors</b> |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b></b>   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br><b></b>   |                              |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b></b>                        |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br><b></b>   |                              |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>October 26, 1984</b> to <b>November 8, 1984</b> , that (I) (we) last saw the deceased alive on <b>November 8, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |                              |  |  |
| 22b. SIGNATURE<br><b>Michael J. McHugh</b>  |  |   |   | DEGREE<br><b></b>   |                              | 22c. DATE SIGNED<br>Month <b>11-8-84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Michael J. McHugh</b>   |  |   |   | 22e. ADDRESS<br><b>Union Memorial Hospital</b>  |                              |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>NOV. 10, '84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>NEW CATHEDRAL CEMETERY</b>   |                              | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTIMORE, MD</b>  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>WILLIAM E. JOHNSON</b>  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 9 1984</b>  |                              | 25b. REGISTRAR'S SIGNATURE<br><b>Wm. E. Johnson</b>  |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| FOR<br>STATE<br>REGISTRAR  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |   | REG. NO.<br>8 4 3 0 1 2 5  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>FRANCIS J. MULVIHILL</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 20, 1984</b>                             |  | 2b. HOUR<br><b>5:32 P.M.</b>   |
| 1. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 8, 1915</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS.<br>IF UNDER 1 YEAR: MONTHS DAYS<br>IF UNDER 24 HRS: HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Purchasing Agent</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Standard Sant.</b>   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frank J. Mulvihill</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rose Carroll</b>                        |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>206-01-4688 A</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Balto., Md.</b><br><b>Thomas C. Mulvihill - 5508 Leith Rd. 21239</b>              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Symptomatic cell carcinoma</b>  |  |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>20 min</b><br><b>12 days</b><br><b>6 years</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>None</b>   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             |  |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)    |   |  |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>OCT 24</b> , 19 <b>84</b> , to <b>Nov 20</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>Nov 20</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Daniel Ford</b>   |  | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED<br><b>11/20/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DANIEL FORD, M.D.</b>  |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital Baltimore MD</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11-24-84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b>  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Parkville, Baltimore, Maryland</b>  |  | 23e. DATE REC'D. BY REGISTRAR<br><b>NOV 26 1984</b>   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ruck Towson Funeral Home, Inc.</b>  |  | ADDRESS<br><b>1050 York Rd. Towson, Md. 21204</b>   |   | 25. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Ponders</b>   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Pages 1 and 2 should be filed within 72 hours after death should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 30126

1. FOR  
STATE  
REGISTRAR

|   |  |  |   |   |   |   |  |  |  |
|---|--|--|---|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Patso Musto</b>   |  |  | 20. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11/25/84</b>          |   |   | 21. HOUR<br><b>6:20<sup>PM</sup></b>  |  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Caucasian</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 15 23</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>61</b> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Caton Manor Nursing Center</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Building</b>             |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Construction</b>               |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>Caton &amp; Wilkens Ave-21227</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James Musto</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b> |   |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>II</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Marian Musto 319 Oak Manor Dr. 21061</b>   |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |   |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><b>DEMENTIA.</b>  |  |  |   |   |   |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>NA</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>NA</b>  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>NA 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br><b>NA</b>   |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>NA</b>  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>NA Baltimore</b>  |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-25-84</b> to <b>11-25-84</b> , that (I) (we) last saw the deceased alive on <b>11-25-84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Surjit</b>   |  | DEGREE   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |   |   |  | 22c. DATE SIGNED<br><b>11/26</b>                                       |  |
| 22d. PHYSICIAN'S NAME<br>(TYPE OR PRINT)<br><b>SURJIT JULKA</b>   |  | 22e. ADDRESS<br><b>107-109 E Saratoga St Baltimore 21202</b>   |   |   |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11/28/84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Crownsville</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Crownsville A.A. Md..</b>                      |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Raymond C. Fink Burnie, Md. 21061</b>  |  |  |   | 25. DATE RECEIVED BY REGISTRAR<br><b>NOV 26 1984</b>  |   |   |  |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 3 0 1 2 7

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>LAURA W. MYERS   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 21 84                        |   |  | 2b. HOUR<br>3 30 AM  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>April 18, 1912  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72<br>YRS                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                     |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE CITY  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Sales Lady |  |
|  |  |  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Hutzlers                                  |  |
| 13a. STATE<br>Maryland   |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br>Baltimore   |  |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  | 13e. STREET ADDRESS / ZIP CODE<br>1503 Railworth Rd. 21218             |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William D. Bell  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Margaret Not Known    |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>218-14-8211 |   | 17. INFORMANT<br>Timonium ADDRESS<br>William Myers 2121 Kimrick Place 21093          |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>HEPATIC ENCEPHALOPATHY</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>HYPERCHOLESTEROLIC METABOLIC ACIDOSIS, RENAL FAILURE</u>  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY OFFICE FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11-16</u> , 19 <u>84</u> , to <u>11-21</u> , 19 <u>84</u> , that (I) (we) lost<br>saw the deceased alive on <u>11-20</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.        |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>Reginald D. Riggsby, MD  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>11-21-84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>REGINALD D. RIGGSBY MD  |  |  |  | 22e. ADDRESS<br>UNION MEMORIAL HOSPITAL<br>201 E. UNIVERSITY PKWY BALTO, MD   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>Nov 24 1984   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Oak Lawn Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck, Inc. Baltimore, Maryland  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 23 1984  |  | 25b. REGISTRAR'S SIGNATURE<br>The Davidson-Randall                             |  |

MEDICAL CERTIFICATION

1  
9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR   |  | 2b. HOUR  |  |
| 1 DECEASED NAME (TYPE OR PRINT)  |  | FIRST MIDDLE LAST  |  | NOVEMBER 3, 1984   |  | 2 P.M.  |  |
| ISABELLE B NAGELL  |  |  |  |  |  |   |  |
| 3. SEX   |  | 4 RACE   |  | 5. DATE OF BIRTH   |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                      |  |
| Female   |  | White  |  | 2 MONTH 11 DAY 1894  |  | 90 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |  |
| Maryland   |  | U.S.A.   |  |  |  | Baltimore MD.   |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| Baltimore  |  | 115 Castlewood Rd.   |  | Homemaker  |  | House   |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  |
| Maryland   |  |  |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  | 13e. STREET ADDRESS / ZIP CODE   |  | 13f. STREET ADDRESS / ZIP CODE                                      |  |
| FIRST MIDDLE LAST  |  | FIRST MIDDLE LAST  |  | 115 Castlewood Rd. 21210   |  |   |  |
| William Nagell   |  | Anna Erich   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS   |  |
| No   |  | 214-24-7605  |  | Miss Annette Nagel   |  | 115 Castlewood Rd. 21210  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  | 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| IMMEDIATE CAUSE (a)  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| (b)  |  |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |
| (c)  |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                |  |  |  |  |  |   |  |
| Cancer of Colon  |  |  |  |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |   |  |
|  |  | P.M. 19  |  |  |  |   |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY   |  | 21f. LOCATION  |  |   |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | STREET CITY OR TOWN COUNTY STATE   |  |   |  |
|  |  |  |  | May 19 68 to Nov 3 84  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from   |  | 22b. SIGNATURE   |  | 22c. DATE SIGNED   |  |   |  |
| saw the deceased alive on  |  | Nov 3 19 84  |  | Nov 4, 84  |  |   |  |
| observed (If not, state (did not) view the body after death.   |  |  |  |  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  | 22f. DATE REC'D. BY REGISTRAR  |  | 22g. REGISTRAR'S SIGNATURE  |  |
| William G. Helfrich M.D.   |  | 5006 Roland Ave. Baltimore, Md. 21210  |  | NOV 7 1984   |  | ma Davidson-Randall   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  |
| Burial   |  | 11-7-84  |  | Holy Cross Cemetery  |  | Brooklyn Anne Arundel Md.   |  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |
| NAME ADDRESS   |  | 6500 York Rd.  |  |  |  |   |  |
| Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212  |  | NOV 7 1984   |  |  |  |   |  |



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 3 0 1 2 9

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |  |
|--|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Betty LEE Neal</b>  |  |   | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>6</b> YEAR <b>84</b>                      |   | 2b. HOUR<br><b>12<sup>10</sup> A<sup>M</sup></b>                     |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>white</b>  | 5. DATE OF BIRTH<br>MONTH <b>11</b> DAY <b>24</b> YEAR <b>35</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>48</b> YRS                  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>                       |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD. |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIV OF MD CANCER CENTER</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>unemployed</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b></b>                         |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE <b>MARYLAND</b> Anne Arundel Co. |  |   | 13b. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 13c. STREET ADDRESS / ZIP CODE<br><b>239 Arundel Beach Rd. 21216</b> |
| 14. FATHER'S NAME<br>FIRST <b>Edward</b> MIDDLE <b>Sterling</b> LAST <b></b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>DORIS</b> MIDDLE <b></b> LAST <b>BUTLER</b>      |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>unknown</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>212 32 6844</b>  |   | 17. INFORMANT<br><b>Chart</b>                                     |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **cardiomyopathy, sepsis**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.(b) **chemotherapy**

DUE TO, OR AS A CONSEQUENCE OF

(c) **diffuse histiocytic lymphoma**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**6 mos****6 mos****unknown**PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: **a**

MEDICAL CERTIFICATION

|   |  |  |  |  |   |
|---|--|--|--|--|---|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/4/84</b> , 19 <b>84</b> , to <b>11/6/84</b> , 19 <b>84</b> , that (I) (we) last<br>saw the deceased alive on <b>11/6/84</b> , 19 <b></b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) did (did not) view the body after death. |  |  |  |  |   |
| 22b. SIGNATURE<br><b>Barbara A. Conley</b>  |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>11/6/84</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BARBARA A. CONLEY MD</b>  |  | 22e. ADDRESS<br><b>UMCC 22 S. Greene St Balto Md</b>                   |  |  |   |

|  |                             |  |  |
|--|-----------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b> | 23b. DATE<br><b>11-9-84</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview-Crem</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Westview-Baltimore Md</b> |
| 24. FUNERAL DIRECTOR<br><b>John A. Baranowski</b>                |                             | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 5 1984</b>         |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, then medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 50M 4/83  
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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 3 0 1 3 0

REG. NO.

|  |  |   |  |   |   |  |   |  |  |
|--|--|---|--|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>GEORGE F. NEHRKORN</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 1 84</b>                  |   |   | 2b. HOUR<br><b>2:40 PM</b>   |   |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 18 10</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS.                                    |   | 7. UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>1 0 0 0</b>  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALT</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SOUTH BALT. GEN. HOSP</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SHIP YARD</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>PAINTER</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>  |  |   |  | 13b. CITY OR TOWN<br><b>PASADENA</b>  |   | 13c. STREET ADDRESS / ZIP CODE<br><b>767 223RD ST / 21122</b>                        |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HERMAN NEHRKORN</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ELIZABETH POTTS</b>   |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>216-10-4719</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>NATHAN NEHRKORN SAME</b>                              |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE &amp; MYOCARD. INF.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>COPD &amp; PNEUMONIA &amp; ASCVD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>TOBACCO USE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>SQUAMOUS CELL CA OF LUNG.</b>  |  |   |  |   |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |
| 22a. I certify that (a) (this hospital) attended the deceased from <b>10/2</b> , 19 <b>84</b> , to <b>11/1</b> , 19 <b>84</b> , that (b) (we) lost<br>saw the deceased alive on <b>10/1</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (b) (we) (did) (did not) view the body after death.   |  |   |  |   |   |  |   |  |  |
| 22b. SIGNATURE<br><b>M. Deringer</b>   |  |   |  |   | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/1/84</b>                                      |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DERINGER</b>   |  |   |  |   | 22e. ADDRESS<br><b>3001 S. HARVOR ST.</b>   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>   |  |   | 23b. DATE<br><b>11 5 84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem Pk</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie AA Md.</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>George Gonce 4001 Ritchie Hwy Balto Md</b>  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 9 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>              |  |  |

MEDICAL CERTIFICATION

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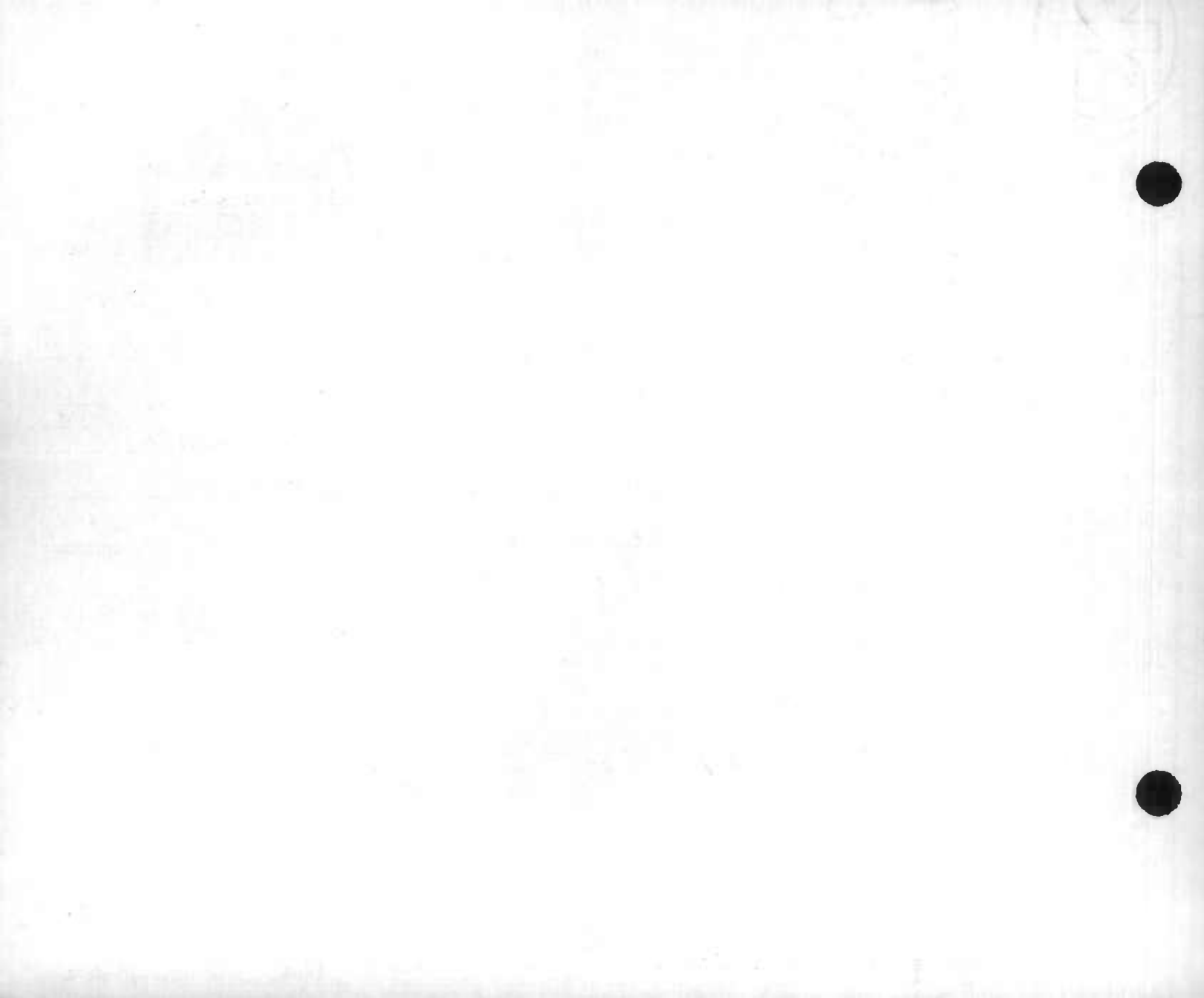
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

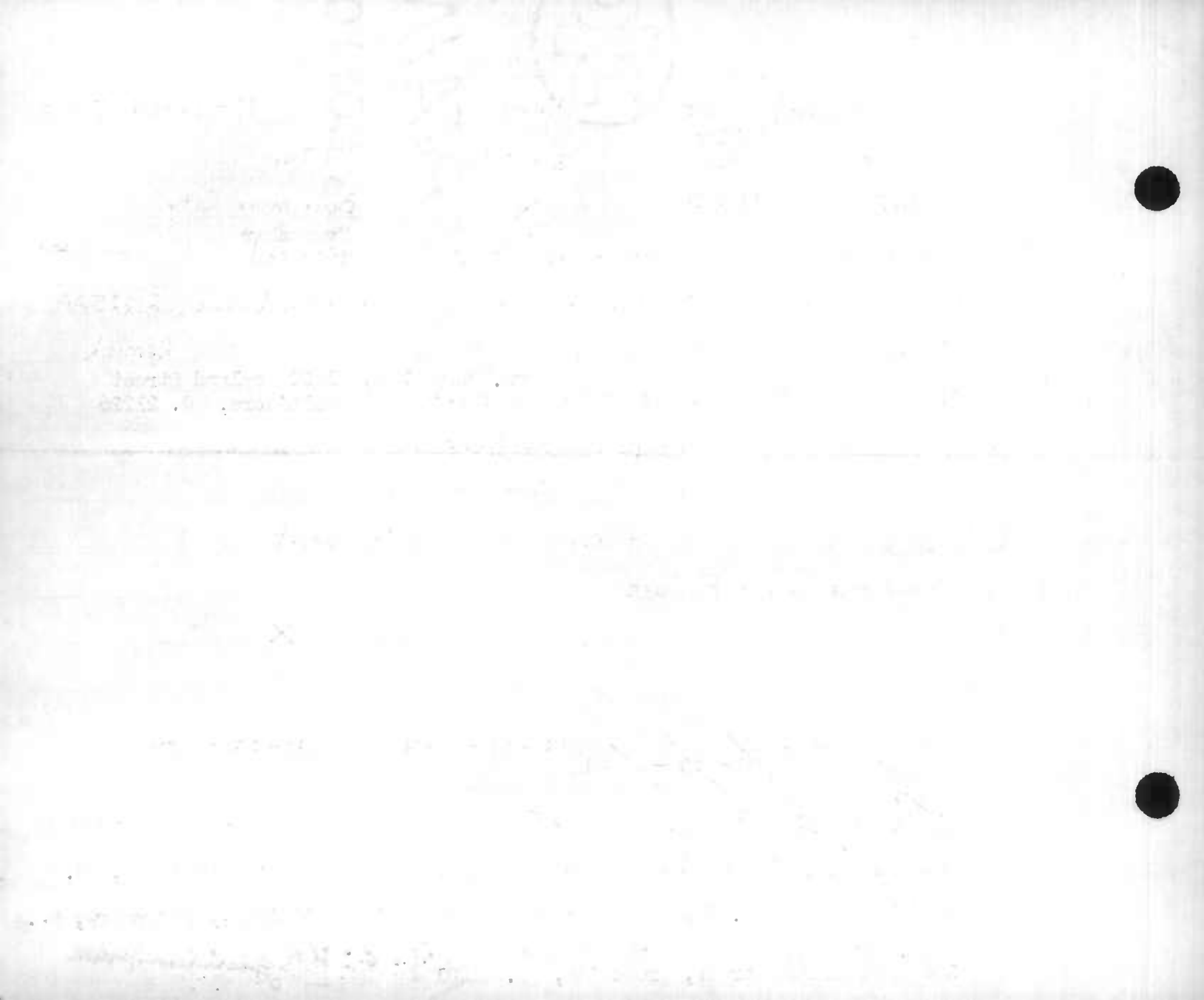
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 3 0 1 3 1

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|--|--|---|--|
| FOR<br>1- STATE<br>REGISTRAR   |  | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><u>Rachel Ann Veri</u>   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><u>11-22-84</u>   |  |
| 3. SEX<br><u>Female</u>  |  | 2b. HOUR<br><u>5:40AM</u>   |  |
| 4. RACE<br><u>White</u>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>77</u> YRS.   |  |
| 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><u>3-17-07</u>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>MD</u>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Baltimore City</u> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><u>Baltimore</u>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>South Baltimore General Hosp.</u> |  |
| 12a. USUAL OCCUPATION<br>(TYPE OR NATURE OF WORKING LIFE)<br><u>Homemaker</u>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>None</u>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><u>MD</u>  |  | 13b. COUNTY<br><u>AA</u>  |  |
| 13c. CITY OR TOWN<br><u>Baltimore</u>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>Luther</u>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>Mary Remick</u>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>No</u>  |  | 16b. SOCIAL SECURITY NO.<br><u>214300538</u>  |  |
| 17. INFORMANT<br><u>Mrs. Mary Wade, Chart</u>  |  | ADDRESS<br><u>1600 Popland Street<br/>Baltimore, Md. 21226</u>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Cardiac Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Right Cerebral Vascular Accident</u>                               |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><u>Congestive Heart Failure</u>  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 21a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  | 21d. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>11-13-1984</u> to <u>11-22-1984</u> , that (I) (we) lost<br>saw the deceased alive on <u>11-22-1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>about the deceased and did not see the body after death. |  |   |  |
| 22b. SIGNATURE<br><u>Dr. Alexander Bogdanchewski MD</u>  |  | 22c. DATE SIGNED<br><u>11-22-84</u>   |  |
| 22d. PHYSICIAN'S PHASE (TYPE OR PRINT)   |  | 22e. ADDRESS<br><u>3001 S. Hanover St. Baltimore, Md.</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Burial</u>  |  | 23b. DATE<br><u>Nov. 24, 1984</u>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>Hyattstown Methodist</u>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Hyattstown, Montgomery, Md.</u>  |  |
| 24. FUNERAL DIRECTOR<br><u>Smith, Keeney and Basford Funeral Home</u>  |  | 25a. DATE REC'D. BY REGISTRAR<br><u>NOV 26 1984</u>   |  |
| 106 East Church Street, Frederick, Md. 21701   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Swinson</u>  |  |

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 3 0 1 3 2

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |   |   |  |   |  |  |  |
|---|--|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>PHILIP PHILIP NEUHAUSER</b>                |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>NOV. 27 1984</b> |   |  | 2b. HOUR<br><b>2:47 P.M.</b>  |  |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>CANADIAN</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>JULY 29 1905</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>OHIO</b>                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>LEVINJAVE HEBREW GERIATRIC CENTER + HOSPITAL</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>ELECTRICIAN</b>          |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>STEEL</b>                      |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>  |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>2 SIERRA CIRCLE APT. 2L 21117</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>SIMON NEUHAUSER</b>                  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>SARAH MANDEL</b>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b> |  | 16b. SOCIAL SECURITY NO.<br><b>219-03-7573</b>   |   | 17. INFORMANT <b>MRS. REVA NEUHAUSER APT. 2L</b><br><b>2 SIERRA CIR., OWINGS MILLS, MD 21117</b>  |  |   |  |  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **ATHEROSCLEROTIC CARDIOVASCULAR DISEASE**

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

MEDICAL CERTIFICATION

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                        |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (this hospital) attended the deceased from <b>11/27</b> 19 <b>84</b> , to <b>11/27</b> 19 <b>84</b> , that (we) last saw the deceased alive on <b>11/27</b> 19 <b>84</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) <b>view the body after death.</b> |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Estrelita O. Ku</b>  |  | DEGREE<br><b>MD.</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/27/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ESTRELITA O. KU</b>   |  | 22e. ADDRESS<br><b>LEVINJAVE HEBREW GERIATRIC CENTER + HOSPITAL, MD</b> |  |   |  |   |  |

|   |  |                                   |  |   |  |   |  |
|---|--|-----------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>  |  | 23b. DATE<br><b>NOV. 29, 1984</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MIKRO KODESH-BETH ISRAEL</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Sol Levinson &amp; Bros., Inc.</b><br>ADDRESS <b>6010 Reisterstown Rd. Balto., md 21215</b> |  |                                   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 3 1984</b>                    |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>             |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified after death.

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INC 6

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by name.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 4 3 0 1 3 3  |                                   |
|---|--|---|--|--|-----------------------------------|
| 1- FOR STATE REGISTRAR  |  |   |  | REG. NO.   |                                   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ROSA MAE NEWBY</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 4, 1984</b>   |  | 2b. HOUR<br><b>12:10am</b>        |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>Black</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 16 03</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.<br>IF UNDER 1 YEAR: MONTHS DAYS<br>IF UNDER 24 HRS: HOURS MIN. |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |                                   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Balto.</b>  | 13c. CITY OR TOWN<br><b>Balto.</b>                               | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                  |                                   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth Jordan</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth Jordan</b>  |  |  |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>N/A</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mary Byrd 2514 E. Madison St.</b>   |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Peripheral Vascular Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Diabetes Mellitus</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>12 hours</b><br><b>Many Years</b><br><b>Many Years</b> |  |   |  |  |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:<br><b>Hypertension</b>   |  |   |  |  |                                   |
| 19a. DATE OF OPERATION<br><b>10/3/84</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Peripheral Vascular Disease</b>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             |                                   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)    |  |  |                                   |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |                                   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/30/84</b> , 19____, to <b>11/4/84</b> , 19____, that (I) (we) last saw the deceased alive on <b>11/3/84</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did) (did not) view the body after death.  |  |   |  |  |                                   |
| 22b. SIGNATURE<br><b>James A. St. Ville MD</b>  |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>11/4/84</b>   |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>James A. St. Ville</b>  |  | 22e. ADDRESS<br><b>Department of General Surgery, Johns Hopkins Hospital<br/>600 N Wolfe St BALTO, MD 21205</b>   |  |  |                                   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11-9-84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn Cem.</b>   |                                   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>  |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Ave.</b>  |  |  |                                   |
| 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 5 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>  |  |  |                                   |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 50M 1/81  
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

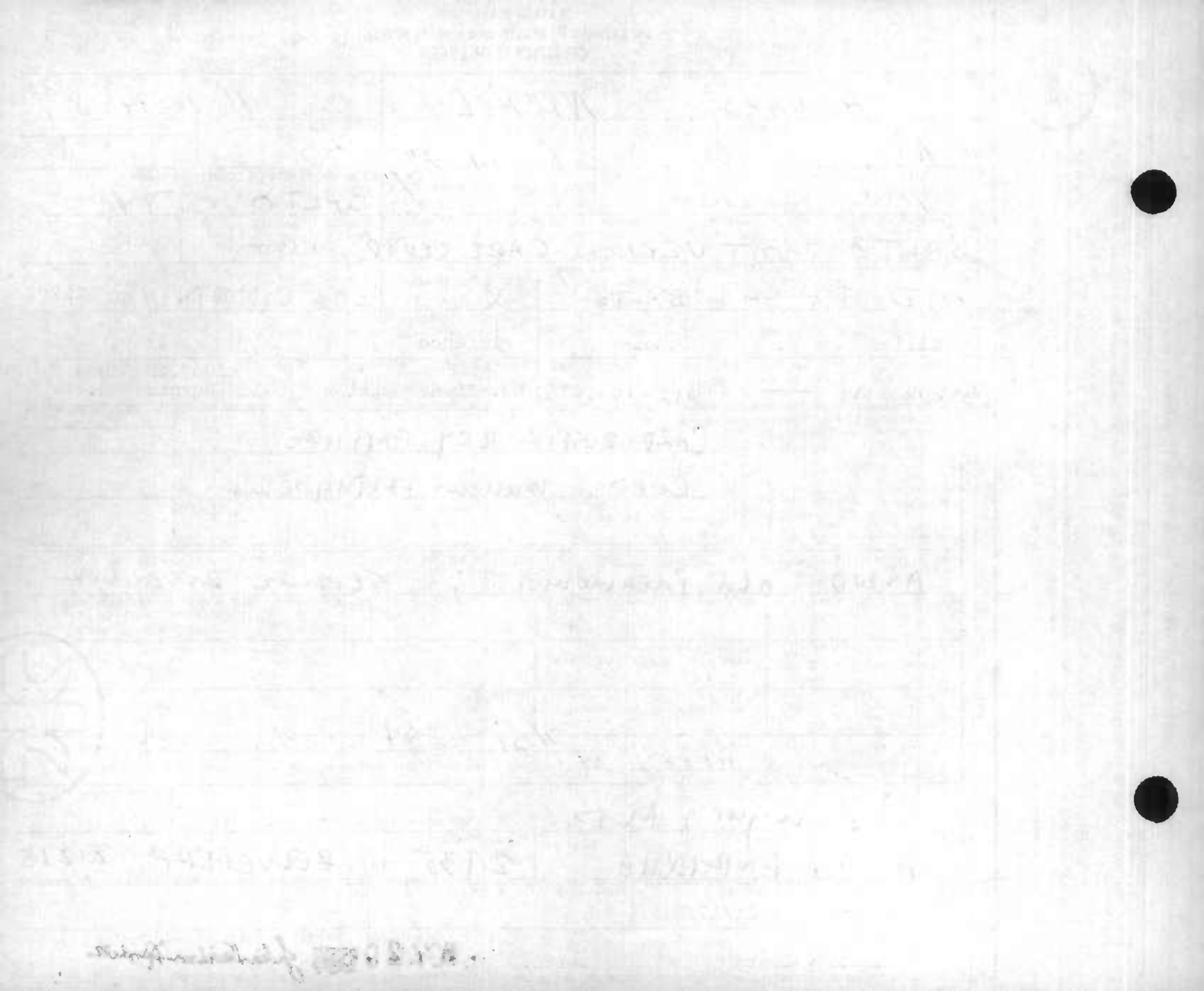
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certificate filed with this one.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8 4 3 0 1 3 4  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |   |  | CERTIFICATE OF DEATH   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   |  | 2a. DATE OF DEATH  |  |  |  |
| FIRST MIDDLE LAST<br><b>HOWARD Nichols</b>   |  |   |  | MONTH DAY YEAR<br><b>11 16 84</b>  |  |  |  |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>W</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 14 29</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>55</b>   |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MT VERNON CARE CENTER</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Delivery</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Printing</b>   |  |
| 13a. STATE<br><b>MD</b>  |  |   |  | 13b. COUNTY<br><b>---</b>  |  | 13c. CITY OR TOWN<br><b>BALTO</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William A. Nichols</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Florence Gray</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Unknown</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>212-26-5672</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Ms. Irene Bettick 200 Oak Lane, S.W. Glen Burnie, Md.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>COPD, BULLOUS EMPHYSEMA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>---</b>   |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>ASWD, old pneumonia; seizure disorder</b>   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/21</b> 19 <b>84</b> to <b>11/16</b> 19 <b>84</b> that (I) (we) last saw the deceased alive on <b>11/16</b> 19 <b>84</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>A. C. ENRIQUE, MD</b>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                              |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A. C. ENRIQUE</b>  |  |   |  | 22e. ADDRESS<br><b>2435 W BELVEDERE 21215</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Removal</b>   |  | 23b. DATE<br><b>11/17/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Anatomy Board</b>   |  |   |  | 25. DATE REC'D. BY REGISTRAR<br><b>NOV 29 1984</b>   |  |  |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson Hordell</b>   |  |  |  |

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 4 3 0 1 3 5  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |  |  | CERTIFICATE OF DEATH   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  |  | 2. DATE OF DEATH   |  |  |  |
| FIRST MIDDLE LAST<br><b>Leon Nixon</b>   |  |  |  | MONTH DAY YEAR<br><b>11 08 84</b>  |  |  |  |
| 3. SEX<br><b>Male</b>  |  |  |  | 2b. HOUR<br><b>9:35 P.M.</b>   |  |  |  |
| 4. RACE<br><b>Black</b>  |  |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>07 31 25</b>  |  |  |  |
| 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>59</b>   |  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS</b>   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>   |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Mt. Vernon Care Center, Inc.</b> |  |  |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. STATE<br><b>Md</b>  |  |  |  | 13b. COUNTY<br><b>Baltimore</b>  |  |  |  |
| 13c. CITY OR TOWN<br><b>Baltimore</b>  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 13e. STREET ADDRESS / ZIP CODE<br><b>1654 Gorsuch Avenue</b>   |  |  |  | 21218  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Cecil Nixon</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lillie Trafton</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>116-18-9867</b>   |  |  |  |
| 17. INFORMANT<br><b>Odessa Spence</b>  |  |  |  | ADDRESS<br><b>1725 Montpelier</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Squamous Cell</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Carcinoma Lung</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____ |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Right Hemiplegia</b>  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                     |  |  |  |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>09/14</b> , 19 <b>84</b> , to <b>11/08</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>11/08</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                        |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>[Signature]</b>   |  |  |  | 22c. DATE SIGNED<br><b>11/9/84</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>S. Autt A</b>  |  |  |  | 22e. ADDRESS<br><b>5400 OLD COURT ROAD RANDALLSTOWN 21137</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |  |  | 23b. DATE<br><b>11/13/84</b>   |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem Park</b>  |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arbutus Md</b>  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>William C. March F/H 1101 E. North Ave</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 13 1984</b>  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |  |  |  |  |  |  |

1

Baltimore City

U.S. National Bank

100 South Avenue

110-11-1807

Photostat of  
Certificate

Register

110-11-1807

110-11-1807

110-11-1807

2. 110-11-1807

2. 110-11-1807

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

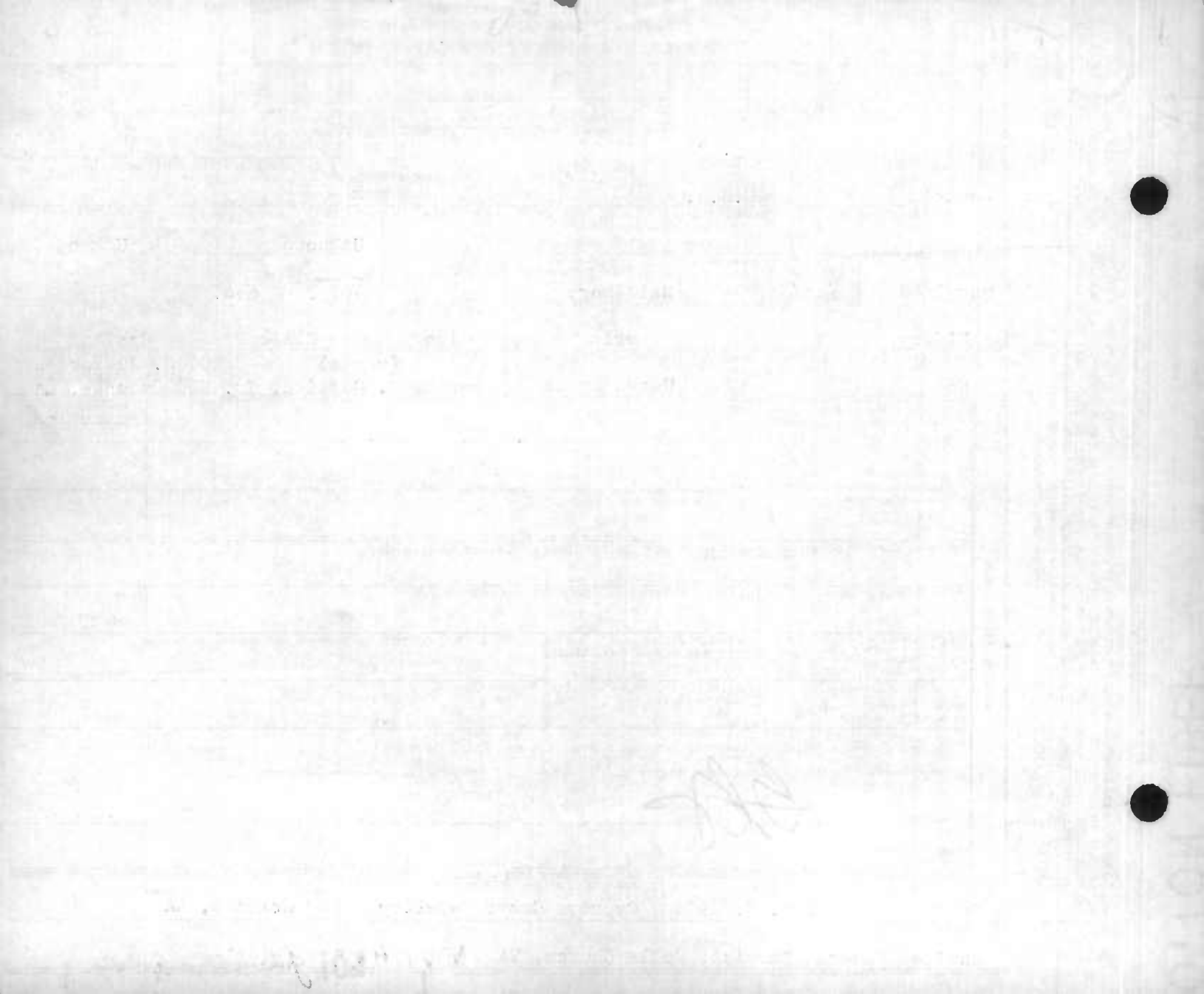
BP  
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(VR A15 ME (5))  
20M 4 / B2

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |           |   |                   |  |                     |   |  |   |  |  |  |
|--|-----------|---|-------------------|--|---------------------|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |           |   |                   |  |                     | 2a. DATE KNOWN OF DEATH ESTIMATED   |  | MONTH DAY YEAR  |  | 2b. HOUR                                     |  |
| John S. Norris   |           |   |                   |  |                     | 11/2/84   |  | 11/2/84   |  | 10:05 AM                                     |  |
| 3. SEX   | 4. RACE   | 5. DATE OF BIRTH  | 6. AGE (IN YEARS) | 7. IF UNDER 1 YR.  | 8. IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD  |  | MONTH DAY YEAR  |  | 2d. HOUR                                     |  |
| Male   | Caucasian | Aug. 23, 1952   | 32 YRS.           |  |                     | 11/2/84   |  | 11/2/84   |  | 10:05 AM                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |           | 7b. CITIZEN OF WHAT COUNTRY?  |                   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                     | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |   |  |  |  |
| Louisiana  |           | U.S.A.  |                   |  |                     | Baltimore City, MD.   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |           | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                   |  |                     | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |
| Baltimore  |           | 407 Park Avenue   |                   |  |                     | Unknown   |  | Unknown   |  |  |  |
| 13a. STATE   |           | 13b. COUNTY   |                   | 13c. CITY OR TOWN  |                     | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS   |  |  |  |
| Maryland   |           | /na/  |                   | Baltimore  |                     | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |  | 407 Park Ave. 21201   |  |  |  |
| 14. FATHER'S NAME  |           |   |                   | 15. MOTHER'S MAIDEN NAME   |                     |   |  |   |  |  |  |
| Sidney Norris  |           |   |                   | Olga Clair Gosling   |                     |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |           | 16b. SOCIAL SECURITY NO.  |                   | 17. INFORMANT (uncle)  |                     | ADDRESS   |  |   |  |  |  |
| No   |           | Unavailable   |                   | Maurice J. Gosling, Jr.  |                     | 204 S. Jefferson Davis Parkway, New Orleans, LA                               |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |           |   |                   |  |                     |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I DEATH WAS CAUSED BY:  |           |   |                   |  |                     |   |  |   |  |  |  |
| IMMEDIATE CAUSE (a) Multiple Shot Gun Wounds   |           |   |                   |  |                     |   |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |           |   |                   |  |                     |   |  |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:  |           |   |                   |  |                     |   |  |   |  |  |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF   |           |   |                   |  |                     |   |  |   |  |  |  |
| (c)  |           |   |                   |  |                     |   |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |           |   |                   |  |                     |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |           |   |                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                     |   |  | 20. AUTOPSY?  |  |  |  |
|  |           |   |                   |  |                     |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |           |   |                   | 21b. TIME OF INJURY  |                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |  |  |
|  |           |   |                   | 10:00 AM 11/2/84   |                     | subject shot  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |           |   |                   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |                     | 21f. LOCATION   |  | CITY OR TOWN  |  | COUNTY STATE                                 |  |
|  |           |   |                   | apartment bldg.  |                     | 407 Park Ave., Balto.   |  | City, Md.   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |           |   |                   |  |                     |   |  |   |  |  |  |
| ACTUAL SIGNATURE   |           |   |                   | TITLE (SPECIFY)  |                     |   |  | DATE SIGNED   |  |  |  |
| Gregory R. Kauffman, M.D.  |           |   |                   | M.D. Assistant   |                     |   |  | 11/2/84   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |           |   |                   | ADDRESS  |                     |   |  |   |  |  |  |
| Gregory R. Kauffman, M.D.  |           |   |                   | 111 Penn St.   |                     |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |           | 23b. DATE   |                   | 23c. NAME OF CEMETERY OR CREMATORY   |                     | 23d. LOCATION   |  |   |  |  |  |
| Burial   |           | Nov. 8, 1984  |                   | Cypress Grove Cemetery   |                     | New Orleans, LA   |  |   |  |  |  |
| 24. FUNERAL DIRECTOR   |           |   |                   | 25a. DATE REC'D. BY REGISTRAR  |                     |   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |
| Capitol Funeral Service, Falls Church, VA  |           |   |                   | Nov 08 1984  |                     |   |  | John Kauffman, Registrar  |  |  |  |



Item 11 per ph 11/16/84

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 3 0 1 3 7

REG. NO.

|  |  |   |   |   |  |   |  |
|--|--|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Effie B. Norwood |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 11 84 |   |  | 2b. HOUR<br>P<br>4:50<br>M  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Aug. 2, 1919  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>65 YRS.                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>City of Baltimore MD.                 |  |
| 10. CITY OR TOWN OF DEATH<br>Balto   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Bon Secour Hosp. |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife |  |
|  |  |   |   |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>-  |  |

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>U.S.A. MARYLAND |  | 13b. CITY OR TOWN<br>Baltimore          |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>221 S. Furrow Street 21223 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Arthur Bane, Sr.   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Helen Malone                                   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No                   |  | 16b. SOCIAL SECURITY NO.<br>200 20 1606 |  | 17. INFORMANT<br>ADDRESS<br>Elbert E. Bane 4015 Falls Road 21211                                |  |  |  |

|   |  |  |  |
|---|--|--|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>Diabetes mellitus</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>minutes</u><br><u>years</u> |  |
|---|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 6</u> 19 <u>84</u> , to <u>Nov 6, 1984</u> , that (I) (we) last saw the deceased alive on <u>Nov 6</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Henry Armanas</u> MD  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>Nov. 12/84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>HENRY ARMANAS   |  |  |  | 22e. ADDRESS<br>1934 Wilkens Ave. Balt., Md. 21223   |  |  |  |

|   |  |                       |  |   |  |   |  |
|---|--|-----------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                             |  | 23b. DATE<br>11/16/84 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Buckingham Cemetery |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Fredericktown RD 1 Pennsylvania |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Burgee-Henss Funeral Home 3631 Falls Road 21211 |  |                       |  | 25a. DATE REC'D. BY REGISTRAR                             |  | 25b. REGISTRAR'S SIGNATURE  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified immediately.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 30M 2/80  
(VRA 15.4)1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND.  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8430138

|   |   |   |   |   |  |
|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Bessie Lee Oglesby   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 20, 1984  |   | 2b. HOUR<br>M   |  |
| 3 SEX<br>Female   | 4 RACE<br>Black   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 12 1917   |   | 6. AGE [IN YEARS LAST BIRTHDAY]<br>67 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>South Carolina   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>324 E. 21st. St. |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RETIRED |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br>MD  |   | 13b. COUNTY   | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>324 E. 21st. St. 21218                                  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George Gary   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Marie Flinney  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>247 302720   |   | 17. INFORMANT ADDRESS<br>Mary Ann Stern 324 E. 21st. St.  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Cardiac arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>atherosclerotic coronary vascular disease</u>   |   |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>minutes<br>minutes<br>years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>cerebrovascular accident</u>  |   |   |   |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |   |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>August</u> 19 <u>84</u> , to <u>November 2</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>OCTOBER</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |   |   |  |
| 22b. SIGNATURE<br><u>Carol Peyser MD</u>  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   | 22c. DATE SIGNED<br>Nov 20 84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Carol Peyser MD  |   | 22e. ADDRESS<br>Wyman Park Health System  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |   | 23b. DATE<br>11/26/84   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Mem. Pk.   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co. MD  |   |   |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H  |   | ADDRESS<br>1101 E. North Ave.   |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 21 1984  |  |
|   |   |   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Haroldson-Randall</u>  |  |

MEDICAL CERTIFICATION



**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. **30139**

1- FOR  
STATE  
REGISTRAR

|  |                              |   |  |   |  |   |  |                                   |  |
|--|------------------------------|---|--|---|--|---|--|-----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>GEORGE A. OKON</b>                               |                              |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> <b>11-15-84</b>  |  |   |  | 2b. HOUR<br><b>2:55A</b>          |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Black</b>      | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 1 42</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>41 YRS.</b> | IF UNDER 1 YR.<br>MONTHS DAYS<br><b>0 0</b>   | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>0 0</b> | 7c. DATE PRONOUNCED DEAD<br><b>11-15-84</b>                       |  | 7d. HOUR<br><b>2:55A</b>          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Nigeria</b>                                |                              | 7b. CITIZEN OF WHAT COUNTRY?<br><b>Nigeria</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>     |  |                                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                              | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>900 Rutland Avenue</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)     |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |                              |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>903 Rutland Ave. 21205</b>              |  |                                   |  |
| 13a. STATE<br><b>Md.</b>   | 13b. COUNTY<br><b>BALTO.</b> | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Alice Okon</b>  |  |   |  |                                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>UNK.</b>                                      |                              | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>220-64-1173</b>  |  | 17. INFORMANT ADDRESS<br><b>Sherry R. Okon 6617 Moonflower Ct</b> |  |                                   |  |

|  |  |  |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gunshot wounds of chest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|--|

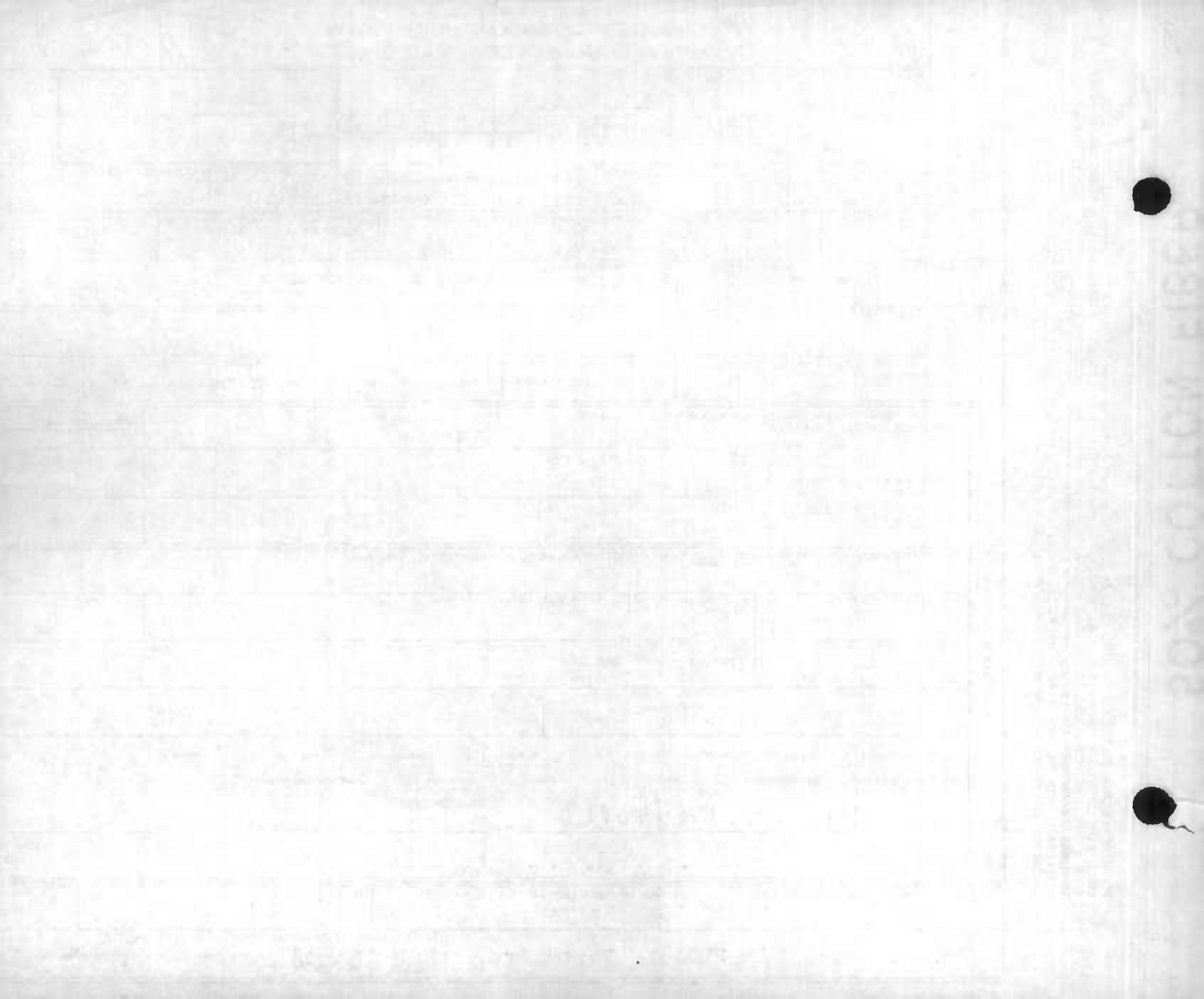
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 21b. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>subject shot during altercation</b> |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>on the street</b>                                     |  | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>900 Rutland Ave. Baltimore, Maryland</b> |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |   |  |   |  |
| ACTUAL SIGNATURE<br><i>Margareta A. Korell</i>   |  | TITLE (SPECIFY)<br><b>M.D. Assistant</b>  |  | DATE SIGNED <b>11-15-84</b>   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Margarita A. Korell, M.D.</b>   |  | ADDRESS<br><b>111 Penn Street</b>   |  |   |  |

|   |                              |   |   |
|---|------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b> | 23b. DATE<br><b>11-23-84</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Eastview Mem. Park</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>       |                              | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 21 1984</b>             |   |
| ADDRESS<br><b>1101 E. North Ave.</b>                          |                              | 25b. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>      |   |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 3 0 1 4 0

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |                                     |  |  |   |
|---|-------------------------------------|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>OLIVER (NEE COOPER) ACQUELINE Y.   |                                     | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 3 84   |  | 2b. HOUR<br>5 AM                              |
| 3. SEX<br>FEMALE  | 4. RACE<br>BLACK                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 4 45   |  | 6. AGE (IN YRS. AND LAST BIRTHDAY)<br>39 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>BALTO. MD  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE MD.   |                                     | 10. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |   |
| 11. CITY OR TOWN OF DEATH<br>BALTO.   |                                     | 12. KIND OF BUSINESS OR INDUSTRY   |  |   |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND |                                     | 13b. COUNTY<br>BALTO   |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>WILBERT COOPER  |                                     | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>EDITH FISHER  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |                                     | 16b. SOCIAL SECURITY NO.<br>214-44-4416  |  | 17. INFORMANT<br>ADDRESS                      |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) RESPIRATORY ARREST

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) INFLAMMATORY CA OF THE BREAST

DUE TO, OR AS A CONSEQUENCE OF

(c)

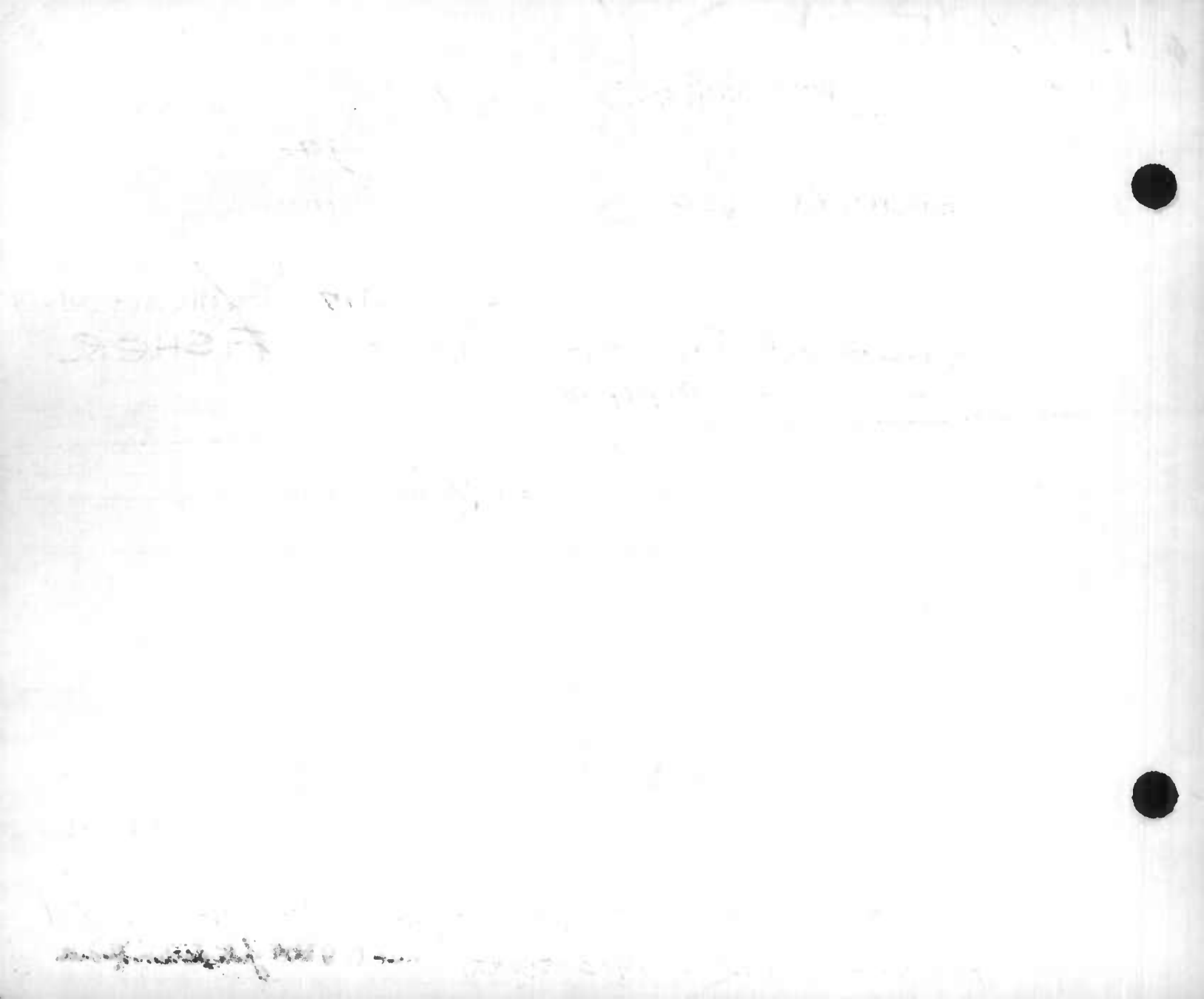
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

|   |  |  |  |
|---|--|--|--|
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11 2 19 84, to 11 3 19 84, that (I) (we) last saw the deceased alive on 11 3 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br>BGMICHAEL   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED<br>11/3/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>BGMICHAEL  | 22e. ADDRESS<br>SINAL HOSPITAL OF BALTIMORE  |  |  |

|   |                        |  |  |
|---|------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL | 23b. DATE<br>11-8-1984 | 23c. NAME OF CEMETERY OR CREMATORY<br>CEDAR HILL | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>HUNTER CO MD |
| 24. FUNERAL DIRECTOR<br>NAME<br>BROWN-THOMPSON      |                        | 25a. DATE REC'D. BY REGISTRAR<br>NOV 0 9 1984    | 25b. REGISTRAR'S SIGNATURE<br>John A. Thompson             |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 3 0 1 4 1

REG. NO.

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |   | 2a. DATE OF DEATH   |   | 2b. HOUR                                   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |   | 2a. DATE OF DEATH   |   | 2b. HOUR                                   |  |
| CHARLES R. O'NEIL Sr.  |   | 11 22 84  |   | 6:15 PM                                    |  |
| 3. SEX   | 4. RACE   | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | IF UNDER 1 YEAR                            |  |
| Male   | White   | 02 05 1917  | 67 YRS.   | IF UNDER 24 HRS.                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |
| Maryland   | U.S.A.  |   | Baltimore City MD.  |  |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |  | 12b. KIND OF BUSINESS OR INDUSTRY                                  |
| Baltimore  | Mercy Hospital Balto. Md.   |   | Truck Driver  |  | Transportation   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   | 13b. COUNTY   | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS                        |  |
| Baltimore  | Baltimore   | Baltimore   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 1605 Harden Ct. Balt, MD 20800             |  |
| 14. FATHER'S NAME  | 15. MOTHER'S MAIDEN NAME  |   | ADDRESS   |  |  |
| Thomas   | Innie   |   | Markel  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   | 16b. SOCIAL SECURITY NO.  | 17. INFORMANT   |   |  |  |
| YES  | 220-03-1958   | Mrs. Edna O'Neil, Same as above   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cat Cell Carcinoma Metastatic<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)  |   |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>Diagnosed 11/84 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |   |   |   |  |  |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  | 20a. AUTOPSY?   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?   |  |  |
|  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |
| 22a. I certify that (a) this hospital attended the deceased from 11/12/84 to 11/22/84, that (b) I lost<br>saw the deceased alive on 11/22/84, and that in my opinion death occurred on the date and hour and from the causes stated<br>above. (c) (d) did not view the body after death. |   |   |   |  |  |
| 22b. SIGNATURE<br>George M Boyer M.D.  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   | 22c. DATE SIGNED<br>11/22/84               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Doctor George Boyer   |   | 22e. ADDRESS  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |   | 23b. DATE   | 23c. NAME OF CEMETERY OR CREMATORY                                  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |
| Burial   |   | Nov. 26, 1984   | McGlenhaven Cemo  | Glen Burne A.A. Co. Md.                    |  |
| 24. FUNERAL DIRECTOR<br>NAME   |   | 25. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE                 |  |
| McCauley Funeral Home  |   | NOV 23 1984   |   | John Davidson                              |  |



STANDARD  
SHEET



20% COTTON FIBRE  
WILKINSON



100% COTTON FIBRE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permits. Then please remove carbon papers. Pages 1 and 2 should be kept within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |   |  |                                 | REG. NO. 84 30142                            |  |                     |  |          |  |
|--|--|--|--|---|--|---|---|--|---------------------------------|--|--|---------------------|--|----------|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   |  |   |   |  |                                 | 2a. DATE OF DEATH MONTH DAY YEAR             |  |                     |  | 2b. HOUR |  |
| 1. DECEASED NAME (TYPE OR PRINT) <i>Mary Rose Onley</i><br><i>Baby Girl Potess</i>   |  |  |  |   |  |   |   |  |                                 | 11-7-84                                      |  |                     |  | 747p M   |  |
| 3 SEX  |  | 4. RACE  |  | 5 DATE OF BIRTH MONTH DAY YEAR  |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                      |   | 7. IF UNDER 1 YEAR   |                                 | 7b. IF UNDER 2 YRS.                          |  | 8 49                |  |          |  |
| Female   |  | Negro  |  | Nov. 7, 1984  |  | -   |   | MONTHS DAYS  |                                 | HOURS MIN.                                   |  |                     |  |          |  |
| 1a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |   |  |                                 |  |  |                     |  |          |  |
| Maryland   |  | U.S.A.   |  |   |  | Baltimore City MD.  |   |  |                                 |  |  |                     |  |          |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |   | 12b. KIND OF BUSINESS OR INDUSTRY                              |                                 |  |  |                     |  |          |  |
| Baltimore  |  | Scott Key Center   |  |   |  | Child   |   |  |                                 |  |  |                     |  |          |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |  |   |   |  |                                 | 13d. INSIDE CITY LIMITS?                     |  | 13e. STREET ADDRESS |  |          |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 312 W. South St./21701   |                                 |  |  |                     |  |          |  |
| Maryland   |  | Frederick  |  | Frederick   |  |   |   |  |                                 |  |  |                     |  |          |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST   |  |  |  |   | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                |   |   |  |                                 |  |  |                     |  |          |  |
| Claude Westley Onley, Sr.  |  |  |  |   | Rose Mary Morris   |   |   |  |                                 |  |  |                     |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17 INFORMANT  |  | ADDRESS   |   |  |                                 |  |  |                     |  |          |  |
| No   |  | None   |  | Claude W. Onley, Sr., Frederick, MD.  |  | 312 W. South Street   |   |  |                                 |  |  |                     |  |          |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Immaturity</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Resp. failure</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>Clinical intraventricular hemorrhage</i>  |  |  |  |   |  |   |   |  |                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                     |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |   |  |                                 |  |  |                     |  |          |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                                 |  |  |                     |  |          |  |
| NA   |  | NA   |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                 |  |  |                     |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> NA OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  | NA.   |   |  |                                 |  |  |                     |  |          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  | NA.   |   |  |                                 |  |  |                     |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11-7</i> , 19 <i>84</i> , to <i>11-7</i> , 19 <i>84</i> , that (I) (we) lost saw the deceased alive on <i>11-7</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |   |  |                                 |  |  |                     |  |          |  |
| 22b. SIGNATURE <i>Pathak</i>   |  |  |  |   | DEGREE   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED <i>11-7-84</i> |  |  |                     |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>AMBADAS PATHAK, M.D.</i>  |  |  |  |   | 22e. ADDRESS <i>4940 Eastern Ave Baltimore Md. 21224</i> |   |   |  |                                 |  |  |                     |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |   |  |                                 |  |  |                     |  |          |  |
| Burial   |  | 11/9/84  |  | Sunnyside U.M. Cem.   |  | Adamstown, Frederick, MD  |   |  |                                 |  |  |                     |  |          |  |
| 24 FUNERAL DIRECTOR NAME   |  | 1621 Opussumtown Pike<br>G. Douglas Stauffer, Frederick, MD. 21701                                     |  |   |  |   |   |  |                                 |  |  |                     |  |          |  |
| NOV 13 1984  |  | NOV 13 1984  |  |   |  |   |   |  |                                 |  |  |                     |  |          |  |



Figure 1

Figure 2



Figure 3

Figure 4

Figure 5

Figure 6

Figure 7

Figure 8

Figure 9

Figure 10

Figure 11

Figure 12

Figure 13

Figure 14

Figure 15

Figure 16

Figure 17

Figure 18

Figure 19

Figure 20

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed within 72 hours after death. This certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

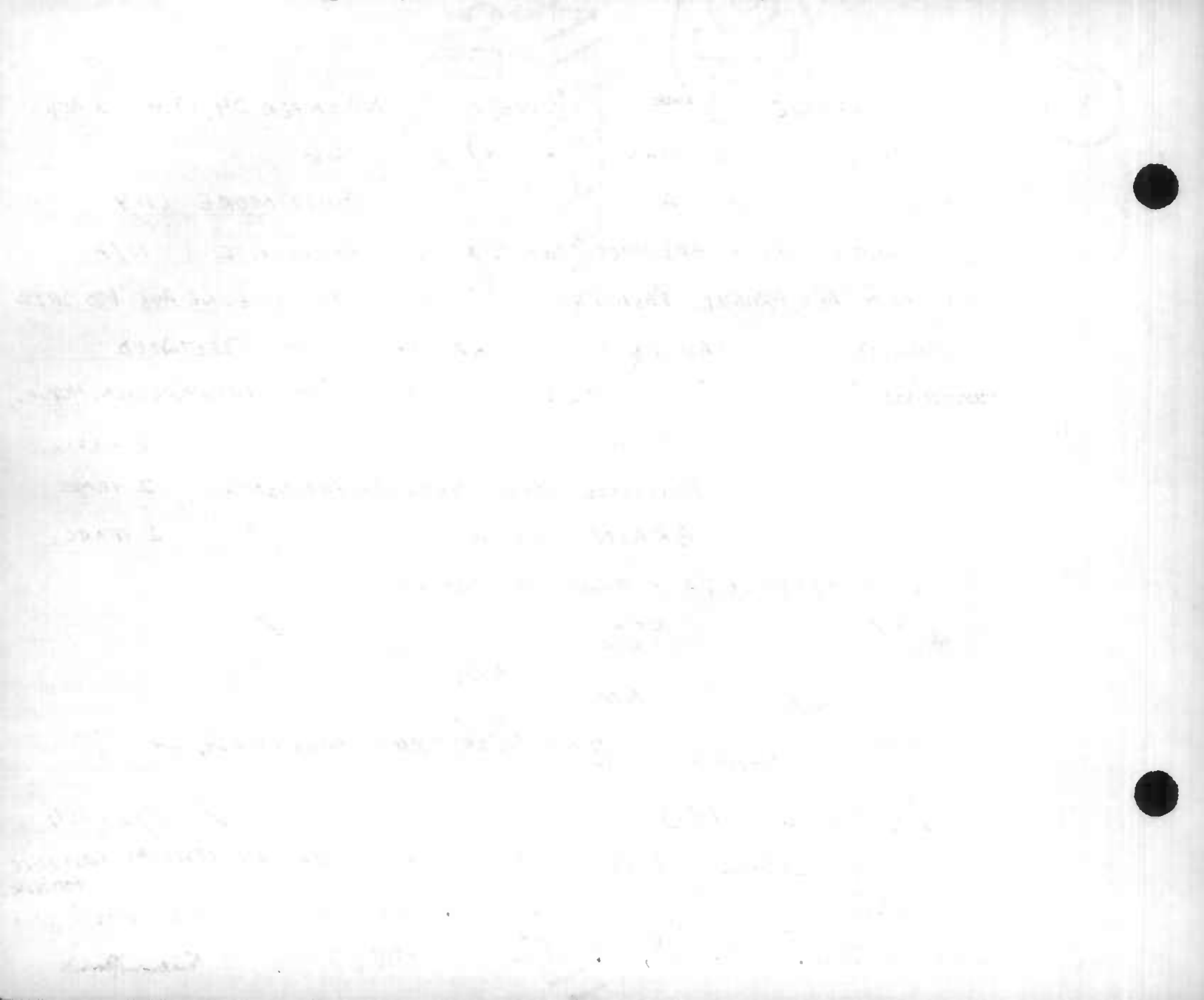
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 3 0 1 4 3

REG. NO.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH   |   | 2b. HOUR   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | MONTH DAY YEAR  |   | MONTHS DAYS HOURS MIN.   |  |
| FIRST MIDDLE LAST   |  | NOVEMBER 24, 1984   |   | 6:30p M  |  |
| TRESSIE Mae OWEN  |  |   |   |  |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)                               | IF UNDER 1 YEAR  |  |
| FEMALE  | CAUCASIAN  | MONTH DAY YEAR  | 66 YRS  | IF UNDER 24 HRS  |  |
|   |  | 10/09/18  |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |  |  |
| Maryland  | U.S.A  |   | BALTIMORE CITY MD.  |  |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY            |
| BALTIMORE   | SOUTH BALTIMORE GEN. HOSPITAL  |   | HOUSE-WIFE  |  | N/A  |
| 13a. STATE  |  | 13b. COUNTY   | 13c. CITY OR TOWN   | 13d. STREET ADDRESS / ZIP CODE   |  |
| MARYLAND  | ANN ARUNDEL  | PASADENA  |   | 7723 CATHERINE AVE. MD. 21122  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |   |  |  |
| FIRST MIDDLE LAST   |  | FIRST MIDDLE LAST   |   |  |  |
| DAVID - FAULKNER  |  | KATTIE - FLEETWOOD  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS  |  |
| NO  |  | 212-28-9303   |   | T.S. SIDHU, MD, 60 SOUTH BALTIMORE GEN. HOSPITAL,                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:   |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) COMA  |  |   |   |  | 6 WEEKS.                                     |
| DUE TO, OR AS A CONSEQUENCE OF (b) MULTIPLE CARDIA-VASCULAR ACCIDENTS   |  |   |   |  | 2 YEARS.                                     |
| DUE TO, OR AS A CONSEQUENCE OF (c) BRAIN TUMOR.   |  |   |   |  | 2 YEARS.                                     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):  |  |   |   |  |  |
| LEFT HEMIPLEGIA & RIGHT HEMIPARESIS   |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?  |  |
| N/A   |  | N/A.  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |
|   |  | HOUR A.M. MONTH DAY YEAR  |   | N/A.   |  |
|   |  | P.M. 19   |   |  |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY  |   | 21f. LOCATION  |  |
| N/A   |  | N/A   |   | STREET CITY OR TOWN COUNTY STATE   |  |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | N/A.   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from NOVEMBER 24, 19 84, to NOVEMBER 24, 19 84, that (I) (we) last saw the deceased alive on NOVEMBER 24, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |  |
| 22b. SIGNATURE  |  | DEGREE  |   | 22c. DATE SIGNED   |  |
| T. S. SIDHU, MD   |  |   |   | 11/24/84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |   |  |  |
| T. S. SIDHU, MD   |  | 60 SOUTH BALTIMORE GEN. HOSPITAL, BALTIMORE   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| Burial  |  | 11/28/84  |   | Meadowridge Mem. Park  |  |
|   |  |   |   | 23d. LOCATION  |  |
|   |  |   |   | CITY OR TOWN COUNTY STATE  |  |
|   |  |   |   | Dorsey Howard Maryland   |  |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE   |  |
| Mc Gully Funeral Home of Pasadena 3204 Mountain Rd. Pasadena, Md. 21122   |  | NOV 27 1984   |   | K. J. J. J.  |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 3 0 1 4 4

REG. NO.

FOR  
1 - STATE  
REGISTRAR

|  |  |   |   |  |
|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>GRACE OWENS</b>   |  | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>1</b> YEAR <b>84</b>  |   | 2b. HOUR <b>2:55 PM</b>                                    |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br><b>Oct. 24, 1907</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b>  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>           |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Walnut Port, Pa.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Francis Scott Key Medical Center</b> | 12a. USUAL OCCUPATION<br>(IF NOT IN SUCH FACILITY, GIVE WORKING LIFE)<br><b>Housewife</b>   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |  |
| 13a. STATE<br><b>Md.</b>   | 13b. COUNTY<br><b>-</b>  | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       | 13e. STREET ADDRESS<br><b>1054 Iris Ave. 21205</b>         |
| 14. FATHER'S NAME<br>FIRST <b>Albert I.</b> MIDDLE <b>Turkington</b> LAST <b>-</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Jennie</b> MIDDLE <b>Caskie</b> LAST <b>-</b>  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  | 16b. SOCIAL SECURITY NO.<br><b>215 10 5647</b>   | 17. INFORMANT<br>ADDRESS <b>Same</b>  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>ATHEROSCLEROTIC CORONARY VASC. Dz.</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>-</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 MIN</b><br><b>YEARS</b> |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>CARCINOMA OF RECTUM, DOSES B</b>  |  |   |   |  |
| 19a. DATE OF OPERATION<br><b>10/17/84</b>  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>CARCINOMA OF RECTUM</b>   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>October 10, 1984</b> , to <b>1 Nov. 1984</b> , that (I) (we) last saw the deceased alive on <b>1 Nov. 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |   |  |
| 22b. SIGNATURE<br><b>TIMOTHY G. BUCHANAN</b>   |  | DEGREE<br><b>M.D.</b>   | 22c. DATE SIGNED<br><b>1 Nov 84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>TIMOTHY G. BUCHANAN</b>  |  | 22e. ADDRESS<br><b>FSKMC, 4940 Eastern Ave, Balto.</b>  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>   | 23b. DATE<br><b>11/5/84</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co., Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>Wardzinski Funeral Home</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 5 1984</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b> |

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2

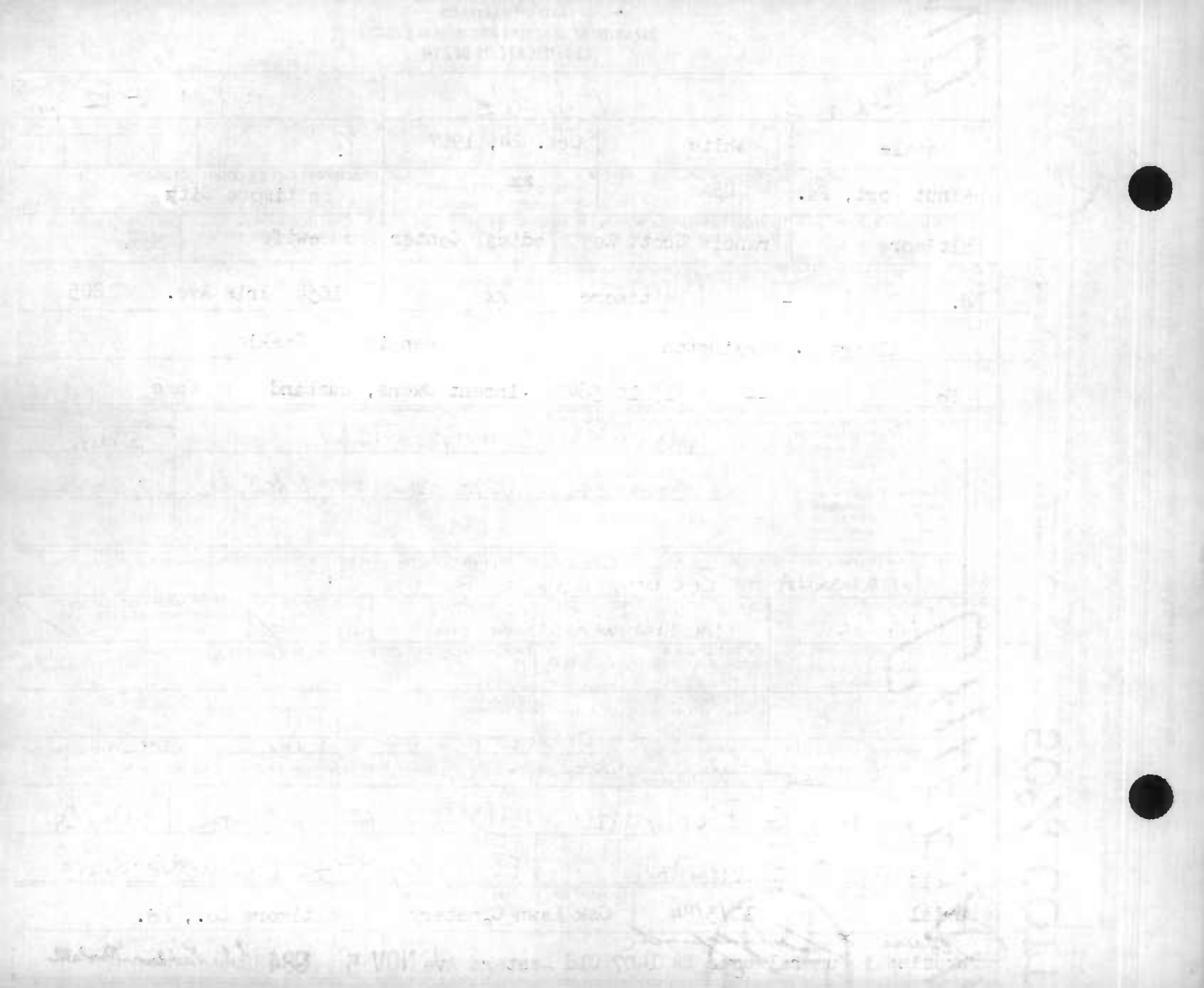
MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, REASON FOR DELAY SHOULD BE STATED. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE. DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

|   |  |        |  |   |  |   |  |   |  |  |  |                                      |  |       |  |  |  |  |  |
|---|--|--------|--|---|--|---|--|---|--|--|--|--------------------------------------|--|-------|--|--|--|--|--|
| items 18-22a 1/21/85 mth  |  |        |  |   |  |   |  |   |  | STATE OF MARYLAND  |  |                                      |  |       |  |  |  |  |  |
| FOR 1-STATE F#599 REGISTRAR UNKN. 84-90   |  |        |  |   |  |   |  |   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |                                      |  |       |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  |  |        |  |   |  |   |  |   |  | 2a. DATE KNOWN OF DEATH MONTH DAY YEAR   |  |                                      |  |       |  |  |  |  |  |
| LATONYA R. OWENS  |  |        |  |   |  |   |  |   |  | 2b. HOUR 19 M  |  |                                      |  |       |  |  |  |  |  |
| 3 SEX   |  | 4 RACE |  | 5 DATE OF BIRTH MONTH DAY YEAR  |  | 6 AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN                          |  | 7c. DATE PRONOUNCED MONTH DAY YEAR  |  | 2d. DATE KNOWN OF DEATH MONTH DAY YEAR   |  | 2e. HOUR 19 M                        |  |       |  |  |  |  |  |
| Female  |  | Black  |  | Aug. 16 68  |  | 16 YRS.   |  | 11/ 18/ 1984  |  | 11/ 18/ 1984   |  | 5:35 A M                             |  |       |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |        |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |       |  |  |  |  |  |
| Baltimore   |  |        |  | USA   |  |   |  |   |  |  |  | Baltimore City, MD.                  |  |       |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |        |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY    |  |       |  |  |  |  |  |
| Baltimore   |  |        |  | 4000 Linkwood Rd.   |  |   |  |   |  |  |  |                                      |  |       |  |  |  |  |  |
| 13a. STATE  |  |        |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS  |  |                                      |  | 21217 |  |  |  |  |  |
| Md.   |  |        |  |   |  | Balto.  |  |   |  | 2212 Brookfield Ave.   |  |                                      |  |       |  |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  |        |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                                    |  |   |  |  |  |                                      |  |       |  |  |  |  |  |
| Edward Owens  |  |        |  |   |  | Earline Lee   |  |   |  |  |  |                                      |  |       |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No   |  |        |  |   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS   |  |  |  |                                      |  |       |  |  |  |  |  |
|   |  |        |  |   |  |   |  | Earlene Owens 2212 Brookfields Ave.   |  |  |  |                                      |  |       |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |        |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |  |                                      |  |       |  |  |  |  |  |
| PART I DEATH WAS CAUSED BY:   |  |        |  |   |  |   |  |   |  |  |  |                                      |  |       |  |  |  |  |  |
| IMMEDIATE CAUSE (a) <u>Narcotism</u>  |  |        |  |   |  |   |  |   |  |  |  |                                      |  |       |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |        |  |   |  |   |  |   |  |  |  |                                      |  |       |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.   |  |        |  |   |  |   |  |   |  |  |  |                                      |  |       |  |  |  |  |  |
| (b) <u></u>   |  |        |  |   |  |   |  |   |  |  |  |                                      |  |       |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |        |  |   |  |   |  |   |  |  |  |                                      |  |       |  |  |  |  |  |
| (c) <u></u>   |  |        |  |   |  |   |  |   |  |  |  |                                      |  |       |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |        |  |   |  |   |  |   |  |  |  |                                      |  |       |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |        |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                      |  |       |  |  |  |  |  |
|   |  |        |  |   |  |   |  |   |  |  |  |                                      |  |       |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |        |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |  |   |  |  |  |                                      |  |       |  |  |  |  |  |
|   |  |        |  | P.M. 11/? 1984  |  | ingestion of drugs  |  |   |  |  |  |                                      |  |       |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |        |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |  |   |  |  |  |                                      |  |       |  |  |  |  |  |
|   |  |        |  | unknown   |  | Baltimore, Md.  |  |   |  |  |  |                                      |  |       |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> . |  |        |  |   |  |   |  |   |  |  |  |                                      |  |       |  |  |  |  |  |
| ACTUAL SIGNATURE  |  |        |  | TITLE (SPECIFY)   |  |   |  | DATE SIGNED   |  |  |  |                                      |  |       |  |  |  |  |  |
| <i>Margarita A. Korell</i>  |  |        |  | M.D. Assistant MEDICAL EXAMINER   |  |   |  | 11/18/84  |  |  |  |                                      |  |       |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |  |        |  | ADDRESS   |  |   |  |   |  |  |  |                                      |  |       |  |  |  |  |  |
| Margarita A. Korell, M.D.   |  |        |  | 111 Penn St.  |  |   |  |   |  |  |  |                                      |  |       |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |        |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |  |  |                                      |  |       |  |  |  |  |  |
| Burial  |  |        |  | 11-24-84  |  | Balto. Nat.   |  | Balto. Md.  |  |  |  |                                      |  |       |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME   |  |        |  | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |                                      |  |       |  |  |  |  |  |
| Wm. C. March F/H 1101 E. North Ave.   |  |        |  |   |  | NOV 21 1984   |  | <i>Margaret A. Korell</i>   |  |  |  |                                      |  |       |  |  |  |  |  |

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AND



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   |  |   |  |  |  |
| 2. DECEASED NAME FIRST MIDDLE LAST<br>WILLIAM L. PADGETT  |  |   |  |   |  |   |  |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Nov. 21, 1910  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.                                |  | 7. DATE OF DEATH MONTH DAY YEAR<br>11-27-84  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALT. City MD.                    |  | 10. CITY OR TOWN OF DEATH<br>BALTIMORE City  |  |
| 11. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>Md   |  | 12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1235 W. 37th Street 21211 |  | 13. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Pipe Fitter   |  | 14. KIND OF BUSINESS OR INDUSTRY<br>Chemical                              |  | 15. CITY OR TOWN OF DEATH<br>BALTIMORE City  |  |
| 16. FATHER'S NAME FIRST MIDDLE LAST<br>James Ernest Padgett   |  | 17. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Mollie Gwaltney   |  | 18. STATE<br>Md   |  | 19. COUNTY<br>---   |  | 20. CITY OR TOWN<br>Baltimore  |  |
| 21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes   |  | 22. SOCIAL SECURITY NO.<br>WWII 213 10 5382   |  | 23. INFORMANT<br>Laura Padgett  |  | 24. ADDRESS<br>same   |  | 25. STREET ADDRESS<br>1235 W. 37th Street 21211  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiovascular collapse<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Immediate |  |   |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from July 19 64 to Nov 19 84, that (I) (we) lost saw the deceased alive on above, (I) (we) (did) (did not) view the body after death, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Sheldon Goldgeier MD  |  |   |  | 22c. DATE SIGNED<br>11-27-84  |  |   |  | 22d. ADDRESS<br>711 W 40 <sup>th</sup> Street, Baltimore MD 21211  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>11/30/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Cross Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Glen Burnie A.A. Co. Md.    |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME Burgee-Henss Funeral Home  |  |   |  | 25. DATE REC'D. BY REGISTRAR<br>NOV 30 1984   |  | 26. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall                       |  |  |  |

UNITED STATES GOVERNMENT

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 4 3 0 1 4 7

|  |  |   |   |  |   |  |
|--|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>LUKE (Paige) (PAGE)</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 30, 1984</b>           |  | 2b. HOUR<br>A M<br><b>12:03</b>   |  |
| 3 SEX<br><b>Male</b>   | 4 RACE<br><b>Black</b>   | 5. DATE OF BIRTH<br>MONTH DAY YR<br><b>8 24 96</b>  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b>  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS.  |
| 7a BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>S. C.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |   |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>  |  |   | 13b. COUNTY<br><b>BALTO.</b>  | 13c. CITY OR TOWN<br><b>BALTO.</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joe Paige</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Josephine Godbold</b> |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>251-16-9752</b>  |   | 17. INFORMANT ADDRESS<br><b>Lucille Holloway 827 Abbott Ct.</b>  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a). <b>cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Recent heart attack</b>  |  |   |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>29 November 19 84</b> to <b>30 November 19 84</b> , that (I) (we) lost<br>saw the deceased alive on <b>30 November 19 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Alison Freifeld</b>   |  | DEGREE<br><b>MD</b>   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>11/30/84</b>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ALISON FREIFELD</b>  |  | 22e. ADDRESS<br><b>THE JOHNS HOPKINS HOSPITAL<br/>600 N. BROADWAY BALTO. MD 21205</b>   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>12-5-84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Ceme.</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto Md.</b>   |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Ave.</b>  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 4 1984</b>   |   |  |
|  |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>in [Signature]</b>  |   |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other medical condition, a medical examiner must be notified at once.

DIVISION OF VITAL RECORDS-201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 3 0 1 4 8

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |                                     |   |  |   |                |  |                                     |  |                               |   |
|--|-------------------------------------|---|--|---|----------------|--|-------------------------------------|--|-------------------------------|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |                                     | REGINALD<br>BABY  |  | MIDDLE<br>BOY   | LAST<br>PALMER | JR.  | 2a. DATE OF DEATH<br>MONTH DAY YEAR | NOVEMBER 16, 1984  |                               | 2b. HOUR<br>4:08 <sub>M</sub>                                     |
| 3. SEX<br>MALE   | 4. RACE<br>BLACK                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR  |  | 11/15/1985  |                | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS      |  | IF UNDER 24 HRS<br>HOURS MIN. |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |                                     | 12b. KIND OF BUSINESS OR INDUSTRY  |                               |   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>JOHNS HOPKINS HOSPITAL                         |  |   |                | 12c. STREET ADDRESS / ZIP CODE<br>2317 E. JEFFERSON ST. 21205  |                                     |  |                               |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br>MARYLAND   |                                     | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                |  |                                     |  |                               |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>REGINALD PALMER  |                                     | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>THERESA BOYD   |  |   |                |  |                                     |  |                               |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |                                     | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br>THERESA PALMER ABOVE   |                |  |                                     |  |                               |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>PULMONARY HYPOPLASIA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |                                     |   |  |   |                |  |                                     |  |                               | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 min<br>21 Hours |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>PREMATURITY</u>  |                                     |   |  |   |                |  |                                     |  |                               |   |
| 19a. DATE OF OPERATION   |                                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |                | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                               |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                |  |                                     |  |                               |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |                                     | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                |  |                                     |  |                               |   |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>15 NOV 84</u> to <u>16 NOV 84</u> , that (1) (we) lost saw the deceased alive on <u>16 NOV 84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did not view the body after death.   |                                     |   |  |   |                |  |                                     |  |                               |   |
| 22b. SIGNATURE<br><u>[Signature]</u> MD.   |                                     | DEGREE  |  |   |                | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                     | 22c. DATE SIGNED<br>11/16/84   |                               |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>BARRY J. BYRNE  |                                     | 22e. ADDRESS<br>600 N. WOLFE ST. BALTO. MD 21205  |  |   |                |  |                                     |  |                               |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |                                     | 23b. DATE<br>11/19/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>JHH   |                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MD. 21205  |                                     |  |                               |   |
| 24. FUNERAL DIRECTOR<br>NAME   |                                     | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br>NOV 29 [Signature]  |  |   |                |  |                                     |  |                               |   |

MEDICAL CERTIFICATION

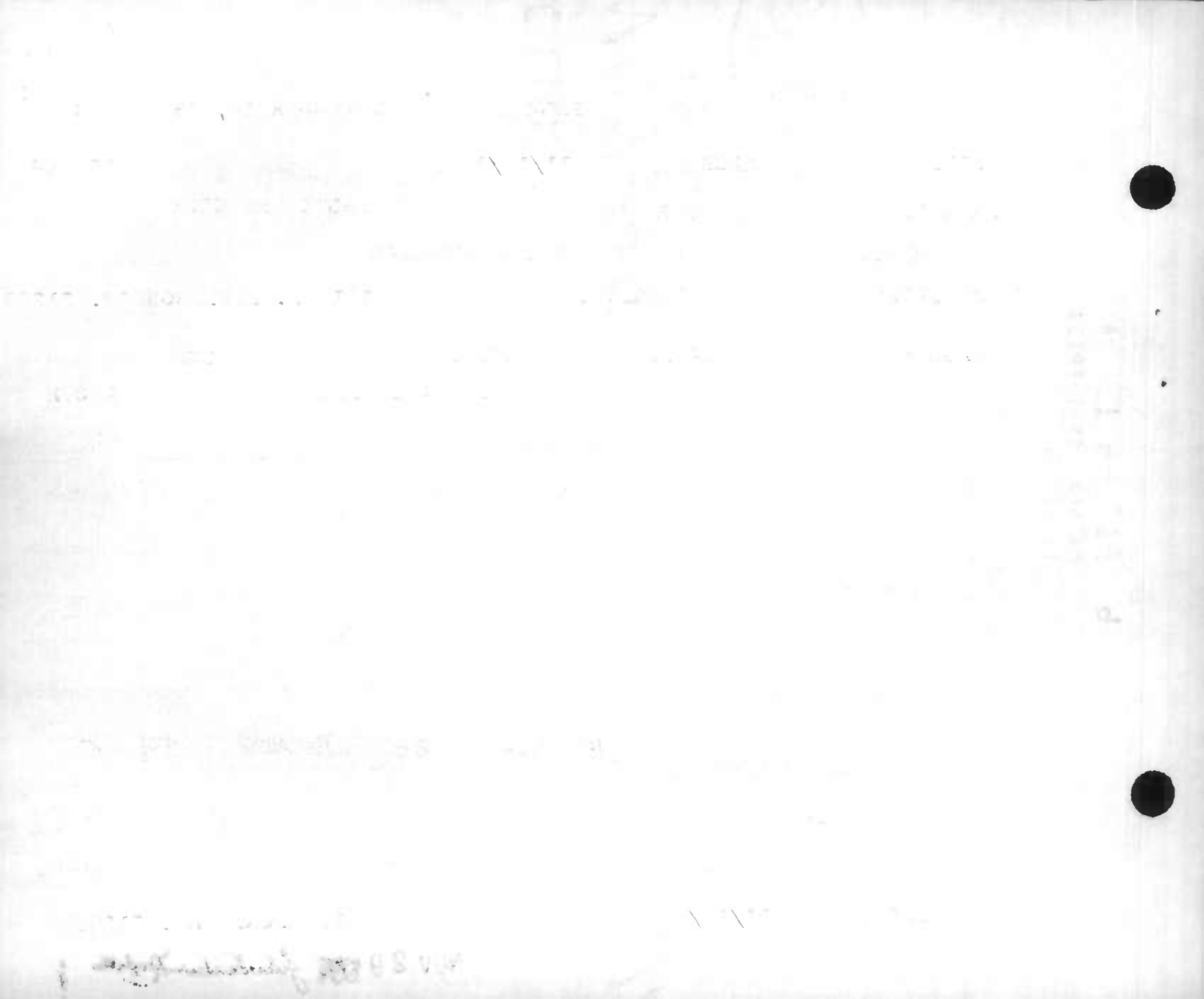
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 1 of this certificate should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 3 0 1 4 9  
REG. NO.

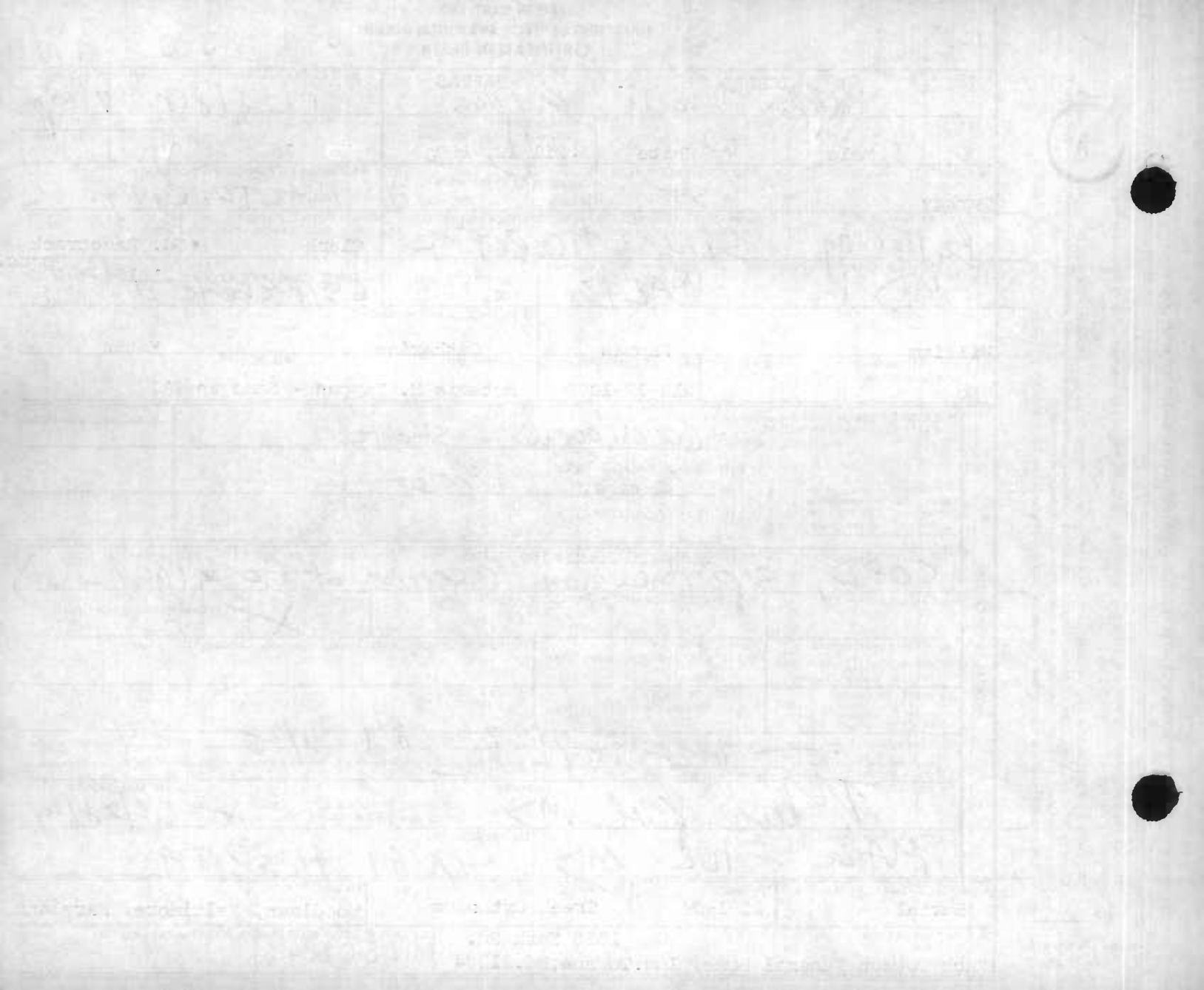
1- FOR  
STATE  
REGISTRAR

|   |   |   |   |  |
|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MICHAEL W. PAPPAS</b>                  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11/28/84</b>   |   | 2b. HOUR<br><b>7:10 PM</b>                                       |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>April 12, 1908</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Turkey</b>                    | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. CITY</b> MD.   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                 | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Clerk</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>md. Racetrack Assoc.</b> |
| 13a. STATE<br><b>MD</b>   |   | 13b. COUNTY<br><b>BALTO</b>   | 13c. STREET ADDRESS / ZIP CODE<br><b>6518 Eberle Dr. MD 21215</b>             |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>William Pappas</b>                  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Catherine Kazan</b>  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)<br><b>No</b> |   | 16b. SOCIAL SECURITY NO.<br><b>218-32-1379</b>  |   | 17. INFORMANT ADDRESS<br><b>Artemis M. Pappas - Same as #13</b>  |

|   |  |  |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>Cardiogenic Shock</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|--|

|  |   |   |  |
|--|---|---|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a<br><b>COPD, s/p Aneurysm (resection of Aorta (Abdominal))</b>   |   |   |  |
| 19a. DATE OF OPERATION<br><b>11/28/84</b>  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>resection of Aorta (Abdominal)</b> | 20. AUTOPSY?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                         | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                    |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/28/84</b> 19 <b>84</b> to <b>11/28/84</b> 19 <b>84</b> that (I) (we) last saw the deceased alive on <b>11/28/84</b> 19 <b>84</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |   |   |  |
| 22b. SIGNATURE<br><b>MARC PAUL MD</b>  | DEGREE<br><b>MD</b>   | 22c. DATE SIGNED<br><b>11/28/84</b>   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARC PAUL MD</b>   |   | 22e. ADDRESS<br><b>SINAI HOSPITAL</b>   |  |

|   |                             |   |  |
|---|-----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>  | 23b. DATE<br><b>12-1-84</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greek Orthodox</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Woodlawn, Baltimore, Maryland</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b> |                             | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 30 1984</b>         | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                   |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 3 0 1 5 0

REG. NO.

|  |  |                       |   |   |                                    |   |   |  |   |  |  |
|--|--|-----------------------|---|---|------------------------------------|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>William H. PASCO</b>  |  |                       | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>24</b> YEAR <b>84</b>   |   |                                    | 2b. HOUR<br><b>9:25</b> A.M.  |   |  |   |  |  |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>Blk</b> |   | 5. DATE OF BIRTH<br>MONTH <b>4</b> DAY <b>21</b> YEAR <b>1929</b> |                                    | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>55</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b> |   | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto. Md.</b>   |  |                       | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |                                    | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |                       | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Ben Secor</b> |   |                                    | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>STEEL Worker</b>   |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>STEEL</b>   |  |  |
| 13a. STATE<br><b>Md.</b>   |  |                       | 13b. COUNTY<br><b>Balto.</b>  |   | 13c. CITY OR TOWN<br><b>Balto.</b> |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>1911 Ruxton Ave. 21216</b>   |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Elijah</b> MIDDLE <b>Pasco</b> LAST <b>Pasco</b>   |  |                       | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Susie</b> MIDDLE <b>Wolfolk</b> LAST <b></b>   |   |                                    |   |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  |                       | 16b. SOCIAL SECURITY NO.<br><b>219-24-3111</b>  |   |                                    | 17. INFORMANT<br><b>Mrs. Hovey Pasco</b>  |   |  | ADDRESS<br><b>1911 Ruxton Ave.</b>  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Courose static disorientation synd</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Retrosymptomatic squamous cell carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Brain metastasis</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b> |  |                       |   |   |                                    |   |   |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Pan Sinusitis + HBP.</b> |  |  |
| 19a. DATE OF OPERATION   |  |                       | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |                                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                      |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                       | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                       | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   |                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/4/84</b> to <b>11-24</b> 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>11-23 84</b> 19 <b></b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |                       |   |   |                                    |   |   |  |   |  |  |
| 22b. SIGNATURE<br><b>[Signature]</b>   |  |                       | DEGREE <b>MD</b>  |   |                                    | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |   |  | 22c. DATE SIGNED<br><b>11/24/84</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Harold R. ARBUZUS MD</b>   |  |                       | 22e. ADDRESS<br><b>1940 N. Balto-St Balto. Md 2123</b>  |   |                                    |   |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |                       | 23b. DATE<br><b>11/29/84</b>  |   |                                    | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus</b>  |   |  | 23d. LOCATION<br>CITY OR TOWN <b>Balto</b> COUNTY <b>Md.</b> STATE <b></b>  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Jas. A. Morton &amp; Sons</b> ADDRESS <b>1701 LAURENS</b>  |  |                       |   |   |                                    | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 26 1984</b>   |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are based on the principles of wave mechanics.

2. The second part of the paper is devoted to a discussion of the application of the theory of the structure of the atom to the study of the properties of matter. It is shown that the theory of the structure of the atom can be used to explain the properties of matter, such as the properties of the elements and the properties of the compounds.

3. The third part of the paper is devoted to a discussion of the application of the theory of the structure of the atom to the study of the properties of the elements. It is shown that the theory of the structure of the atom can be used to explain the properties of the elements, such as the properties of the elements in the periodic table.

4. The fourth part of the paper is devoted to a discussion of the application of the theory of the structure of the atom to the study of the properties of the compounds. It is shown that the theory of the structure of the atom can be used to explain the properties of the compounds, such as the properties of the compounds in the periodic table.

5. The fifth part of the paper is devoted to a discussion of the application of the theory of the structure of the atom to the study of the properties of the elements and the compounds. It is shown that the theory of the structure of the atom can be used to explain the properties of the elements and the compounds, such as the properties of the elements and the compounds in the periodic table.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1, 2, 3, and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |   |  | REG. NO. 84 30151                            |  |
|--|--|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>AGOSTINO V PASSALACQUA  |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>11 27 84  |  | 2b. HOUR<br>11.05 AM  |  |  |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>MARCH 1, 1907  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>AMEGLIA, ITALY  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY, MD                                      |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>GOODSAMARITAN Hospital. |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>CHEF                           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>RESTAURANT   |  |  |  |
| 13a. STATE<br>MARYLAND   |  | 13b. COUNTY<br>BALTIMORE  |  | 13c. CITY OR TOWN<br>21204  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>8134 Pleasant Plains Rd 21204  |  |  |  |
| FATHER'S NAME FIRST MIDDLE LAST<br>GIUSEPPI PASSALACQUA  |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>DOMENICA LOMBARDI                                 |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>----- 215-10-4750   |  | 17. INFORMANT ADDRESS<br>LOUISE PASSALACQUA BALTO., MD 21204  |  |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>NECROTIZING PANCREATITIS</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>RESPIRATORY FAILURE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br>11-25-84   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>PANCREATITIS  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/21, 19 84, to 11/27, 19 84, that (I) (we) lost saw the deceased alive on 11/27, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Kwang N. Kim   |  | DEGREE<br>MD  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  |   |  | 22c. DATE SIGNED<br>11-27-84  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>KWANG N KIM. MD   |  |   |  | 22e. ADDRESS<br>5801 LOCH RAVEN BLVD<br>GOODSAMARITAN Hospital  |  |   |  | 22f. CITY OR TOWN<br>BALTIMORE, MARYLAND  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>NOV. 30, '84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>HOLY REDEEMER   |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE, MARYLAND   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>WILLIAM E. JOHNSON   |  |   |  | ADDRESS<br>8521 LOCH RAVEN BLVD.  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 29 1984  |  |  |  |
|  |  |   |  |   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson Handall  |  |  |  |

BP \_\_\_\_\_





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 30152

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |  |   |   |   |  |  |
|--|--|---|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Catherine Patterson</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 18 84</b> |   | 2b. HOUR<br><b>7 PM</b>   |   |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Negro</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 11 17</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b>  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>V.A.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. CITY</b> MD.                                  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>FRANCIS SCOTT Key Med. Center</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>LABOR</b>                |  |  |
| 13a. STATE<br><b>M.D.</b>  |  | 13b. COUNTY<br><b>BALTO.</b>  |  | 13c. CITY OR TOWN<br><b>BALTO.</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>MASSEY PATTERSON</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CATHERINE HIGGEBOTTOM</b>   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>219-30-8104</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>MR. LEE 220 Hawthorn Rd.</b>   |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Vegetative state</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cerebrovascular accident</b> |  |   |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a  |  |   |  |   |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |   |   |  |  |
| 22b. SIGNATURE<br><b>J. Leaf MD</b>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   | 22c. DATE SIGNED<br><b>11/19/84</b>   |  |  |
| 22d. PHYSICIAN'S NAME (IF DIFFERENT)<br><b>J. Leaf, M.D.</b>   |  |   |  | 22e. ADDRESS<br><b>Francis Scott Key Medical Center</b>   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPONSOR)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>11-24-84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Christian Aid Cem</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Amherst V.A.</b>                               |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Bell FH 1129 N. Caroline</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 20 1984</b>   |   |   |  |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Lia Davidson-Randall</i>   |   |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 30153

|  |  |  |   |  |  |  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |
|--|--|--|---|--|--|--|--|--|---|--|--|---|--|--|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST<br>Doris  |  |  | MIDDLE<br>Patterson  |  |  | LAST  |  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR |  |  | 2b. HOUR   |  |  |   |  |  |
| 3. SEX<br>Female   |  |  | 4. RACE<br>Black  |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10-9-1928  |  |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>55 YRS.   |  |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |  |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>11-21-84 |  |  | 7d. HOUR<br>3:47 a.m.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balto. Md.  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                     |  |  |   |  |  |  |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1040 N. Bentalou Street |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Factory Worker  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |   |  |  |  |  |  |   |  |  |
| 13a. STATE<br>Md.  |  |  | 13b. COUNTY   |  |  | 13c. CITY OR TOWN<br>Balto   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET ADDRESS<br>1040 N. Bentalou Street  |  |  |  |  |  |   |  |  |
| 14. FATHER'S NAME<br>John  |  |  | MIDDLE  |  |  | LAST<br>Patterson  |  |  | 15. MOTHER'S MAIDEN NAME<br>Bertha  |  |  | MIDDLE<br>Wilson  |  |  | LAST   |  |  |   |  |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |  |  | (IF YES, GIVE WAR OR DATES)   |  |  | 16b. SOCIAL SECURITY NO.<br>220-20-3494  |  |  | 17. INFORMANT<br>Audrey Smith   |  |  | ADDRESS<br>3710 Cranston Ave  |  |  |  |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |  |   |  |  |  |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH           |  |  |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |  |  |   |  |  |  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |  |  |   |  |  |   |  |  |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |   |  |  |  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |
| ACTUAL SIGNATURE<br>Dennis F. Smyth M.D.   |  |  | TITLE (SPECIFY)<br>Assistant  |  |  | MEDICAL EXAMINER   |  |  | DATE SIGNED<br>11-21-84   |  |  |   |  |  |  |  |  |   |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Dennis F. Smyth, M.D.   |  |  | ADDRESS<br>111 Penn St., Balto., Md. 21201  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |  | 23b. DATE<br>11-26-84   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Calvary Cem.   |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Md.  |  |  |   |  |  |  |  |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Brown Thompson F.H.  |  |  | ADDRESS<br>1913 W. Baltimore St.  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 26 1984   |  |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson  |  |  |   |  |  |  |  |  |   |  |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

20% COTTON FIBER

MADE IN U.S.A.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

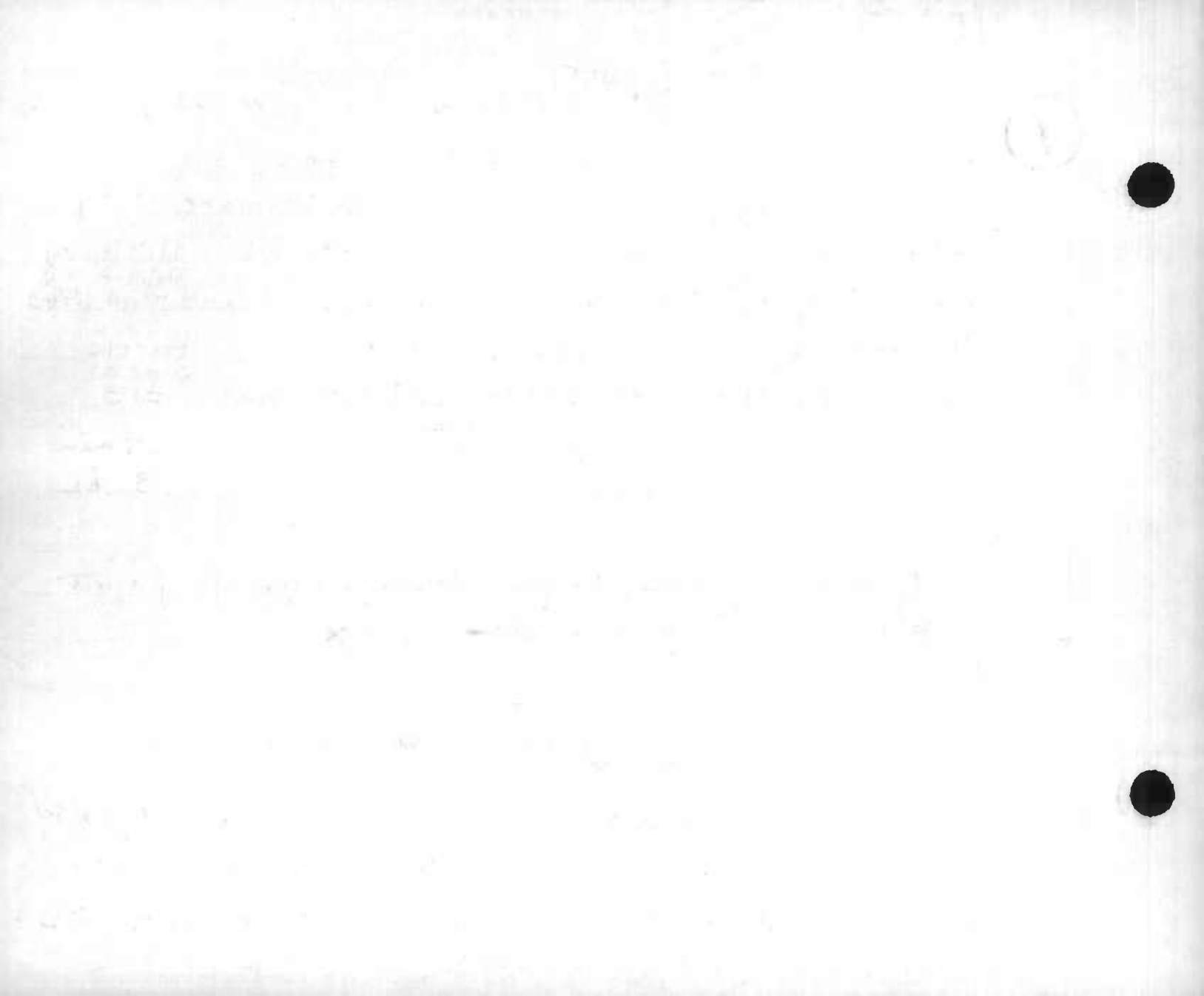
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 4 3 0 1 5 4   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>GORDON Alexander PATTERSON</b>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11 23 84</b>   |  | 2b. HOUR<br><b>AM</b>   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Jan. 7, 1898</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>86</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Ohio</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Wyman Park Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Navy</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. COUNTY 13d. CITY OR TOWN<br><b>MD VA. A. Annapolis</b>   |  |  |  | 13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13f. STREET ADDRESS / ZIP CODE<br><b>1008 Tallwood Road, 21403</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Walter K. Patterson</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Elsper Harris</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Yes 1919-1946</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>511-40-3160</b>  |  | 17. INFORMANT ADDRESS<br><b>Eleanor K. Patterson - Same as #13</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>3 wks</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>9 min</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Obstructive Jaundice, Profound Neurologic Depression, arrest</b>  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>10/27/84</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Bowel obstruction</b>   |  | 19c. AUTOPSY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |
| 21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21c. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/11/84</b> to <b>11/23/84</b> , that (I) (we) lost the deceased alive on <b>11/23/84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                     |  |  |  |   |  |   |  |
| 22b. SIGNATURE OF PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Wm C Doolay MD</b>   |  |  |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>4/23/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Wm C Doolay MD</b>  |  |  |  | 22e. ADDRESS<br><b>WYMAN PARK Hospital</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>Nov 26, 1984</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Suitland P.G. MD</b>  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Taylor Funeral Chapel Annapolis MD</b>  |  |  |  | 25a. DATE RECD. BY REGISTRAR<br><b>NOV 28 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>W. W. Wadsworth</b>  |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                        |  |   |  |  |   |   |  | REG. NO. 30155   |  |
|--|--|------------------------|--|---|--|--|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>CHARLES R PAYNE</b>  |  |                        |  |   |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>11</b> DAY <b>2</b> YEAR <b>84</b> |   | 2b. HOUR <b>5:11 PM</b>                                    |  |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>Caucas-</b> |  | 5. DATE OF BIRTH MONTH <b>Nov</b> DAY <b>8</b> YEAR <b>1933</b> |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>50</b> YRS.   |   | 7c. DATE PRONOUNCED DEAD MONTH <b>11</b> DAY <b>2</b> YEAR <b>84</b>          |  | 2d. HOUR <b>5:11 PM</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>  |  |                        | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> |  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  |                        | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4812 Curtis Avenue (rear)</b> |   |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Salvage Co.</b>                             |  |
| 13a. STATE <b>Md.</b>  |  |                        | 13b. COUNTY <b>-</b>   |   | 13c. CITY OR TOWN <b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |   | 13e. STREET ADDRESS <b>3861 Elmora Ave. 21213</b>          |  |  |
| 14. FATHER'S NAME FIRST <b>Turell</b> MIDDLE <b>Payne</b> LAST <b>Payne</b>  |  |                        |  |   | 15. MOTHER'S MAIDEN NAME FIRST <b>Sallie</b> MIDDLE <b>English</b> LAST <b>English</b> |  |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>   |  |                        |  | 16b. SOCIAL SECURITY NO. <b>unknown</b>                         |  | 17. INFORMANT <b>Walter R. Payne</b> ADDRESS <b>3816 Elmora Ave.</b>   |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ethanol intoxication</b><br><b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                        |  |   |  |  |   |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>chronic alcoholism</b>   |  |                        |  |   |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  |                        |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?               |  |  |   |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                        |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |   |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                        |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)     |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>    |  |                        |  |   |  |  |   |   |  |  |  |
| ACTUAL SIGNATURE <b>Gregory R. Kauffman</b>  |  |                        |  | TITLE (SPECIFY) <b>M.D. Assistant</b>                           |  |  |   | DATE SIGNED <b>11-3-84</b>  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Gregory R. Kauffman, M.D.</b>   |  |                        |  | ADDRESS <b>111 Penn Street</b>                                  |  |  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>   |  |                        | 23b. DATE <b>11-3-84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Nineveh Church Cem.</b>                          |  |   | 23d. LOCATION CITY OR TOWN <b>Franklin</b> COUNTY <b>Va.</b> STATE <b>Va.</b> |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>Schimunek Funeral Home</b> ADDRESS <b>3331 Brehms Lane</b>  |  |                        |  | 25a. DATE REC'D. BY REGISTRAR <b>NOV 13 1984</b>                |  | 25b. REGISTRAR'S SIGNATURE <b>John B. ...</b>  |   |   |  |  |  |



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 30156

|   |  |   |  |  |  |   |  |   |  |   |  |                                 |  |                 |  |          |  |      |  |
|---|--|---|--|--|--|---|--|---|--|---|--|---------------------------------|--|-----------------|--|----------|--|------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   |  | MIDDLE   |  | LAST  |  | 2a. DATE OF DEATH   |  | MONTH   |  | DAY                             |  | YEAR            |  | 2b. HOUR |  | P    |  |
| CHARLES   |  | PAYTON  |  |  |  |   |  | NOVEMBER 19, 1984   |  |   |  |                                 |  |                 |  | 11:24    |  | AM   |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH   |  | MONTH   |  | DAY   |  | YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY) |  | IF UNDER 1 YEAR |  | MONTHS   |  | DAYS |  |
| MALE  |  | BLACK   |  | 11/18/1911   |  |   |  |   |  |   |  | 73                              |  | YRS.            |  |          |  |      |  |
| 7a. BIRTHPLACE<br>(COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                              |  | BALTIMORE CITY  |  |   |  |                                 |  |                 |  |          |  | MD.  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                 |  | Oyster  |  |   |  |                                 |  |                 |  |          |  |      |  |
| BALTIMORE   |  | THE JOHNS HOPKINS HOSPITAL  |  |  |  |   |  |   |  |   |  |                                 |  |                 |  |          |  |      |  |
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13b. STATE  |  | 13c. COUNTY  |  | 13d. CITY OR TOWN   |  | 13e. INSIDE CITY LIMITS?  |  | 13f. STREET ADDRESS / ZIP CODE                  |  |                                 |  |                 |  |          |  |      |  |
| MARYLAND  |  | BALTIMORE   |  |  |  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 700 N. LUZERNE                                  |  | 21205                           |  |                 |  |          |  |      |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  | ADDRESS   |  |                                 |  |                 |  |          |  |      |  |
| ABRAHAM   |  | MARY  |  | Unkn.  |  | 213015755   |  | CHARLES PAYTON  |  | ABOVE   |  |                                 |  |                 |  |          |  |      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)<br>PART I. DEATH WAS CAUSED BY:  |  | IMMEDIATE CAUSE (a)   |  | DUO TO, OR AS A CONSEQUENCE OF   |  | DUO TO, OR AS A CONSEQUENCE OF                                    |  | DUO TO, OR AS A CONSEQUENCE OF                                      |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |                                 |  |                 |  |          |  |      |  |
|   |  | hypotension   |  |  |  | Intra aortic aneurysm hemorrhage                                  |  |   |  | 30 min  |  |                                 |  |                 |  |          |  |      |  |
|   |  |   |  |  |  |   |  |   |  | 2 day   |  |                                 |  |                 |  |          |  |      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |   |  |  |  |   |  |   |  |   |  |                                 |  |                 |  |          |  |      |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |  |   |  |   |  |                                 |  |                 |  |          |  |      |  |
|   |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>          |  |   |  |   |  |                                 |  |                 |  |          |  |      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |   |  |                                 |  |                 |  |          |  |      |  |
|   |  | P.M. 19   |  |  |  |   |  |   |  |   |  |                                 |  |                 |  |          |  |      |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET  |  | CITY OR TOWN  |  | COUNTY  |  | STATE   |  |                                 |  |                 |  |          |  |      |  |
|   |  |   |  |  |  |   |  |   |  |   |  |                                 |  |                 |  |          |  |      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/17, 1984 to 11/19, 1984, that (I) (we) last saw the deceased alive on 11/19, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE  |  | DEGREE   |  | 22c. DATE SIGNED  |  |   |  |   |  |                                 |  |                 |  |          |  |      |  |
|   |  | Edward Kasper   |  |  |  | 11/19   |  |   |  |   |  |                                 |  |                 |  |          |  |      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |  | 600 N. WOLFE ST. BALTO. MD.  |  | Johns Hopkins Hosp  |  | 21205   |  |   |  |                                 |  |                 |  |          |  |      |  |
|   |  |   |  |  |  |   |  |   |  |   |  |                                 |  |                 |  |          |  |      |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN                                     |  | COUNTY  |  | STATE   |  |                                 |  |                 |  |          |  |      |  |
| Removal   |  | 11/22/84  |  |  |  |   |  |   |  |   |  |                                 |  |                 |  |          |  |      |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |   |  |   |  |                                 |  |                 |  |          |  |      |  |
| Anatomy Board   |  | Balto., Md. NOV 29 1984   |  |  |  |   |  |   |  |   |  |                                 |  |                 |  |          |  |      |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO. 84 30157  |  |   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>EMMANUEL GEORGE PAZARZIS   |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>November 10, 1984   |  | 2b. HOUR<br>11:00 A.M.   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>9 13 11  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Greece   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                       |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Francis Scott Key Medical Center |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Stonemason                     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Construction  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>2815 Creston Road 21222   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>George Pazarzis  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Maria Margaritis   |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>233-48-2246A   |  | 17. INFORMANT ADDRESS<br>Mrs. Fanny Nomikos, 2815 Creston Road Baltimore, Md. 21222   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary of Lung</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1992</u> , 19 <u>  </u> , to <u>11/10</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>19  </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>George J. Denbury MD  |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br>11/12/84  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>G. DENBURY MD  |  | 22e. ADDRESS<br>5113 Fawcett Ave BAL MD  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>11-13-84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Oak Lawn Cemetery   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Baltimore Md.                              |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Ann S. Matthews, 3021 Eastern Ave., Baltimore, Md.   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 13 1984   |  | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randall   |  |   |  |  |  |

BP



UNIVERSITY MICROFILMS

11-11-1960

11-11-1960

11/11/60

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |  |  |   |  |  |
|---|--|---|--|---|--|--|---|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   |  |  |   |  |  |
| CERTIFICATE OF DEATH  |  |   |  |   |  |  |   |  |  |
| REG. NO. 8430158  |  |   |  |   |  |  |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Latoya Pearson</b>   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 25, 1984</b>          |  | 2b. HOUR<br>P <sup>M</sup><br><b>10:10</b>                      |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11/25/84</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><b>20</b>                                 |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>20</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MD</b>   |  |   |  |   | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. STREET ADDRESS / ZIP CODE<br><b>1003 McAleer Ct. 21202</b> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Tennerson Gregory Pearson</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rosalind Cassell</b> |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>N/A</b>   |  | 17. INFORMANT ADDRESS<br><b>Tennerson G. Pearson 1116 Barclay St.</b>   |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Severe Prematurity (24 weeks Gestational age)</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |   |  |   |  |  |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>November 25, 19 84</b> , to <b>November 25, 19 84</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>November 25, 19 84</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) (did) (did not) view the body after death. |  |   |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Michael A. Hanks</b>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |  |   | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Michael Hanks, M.D.</b>   |  |   |  | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11/30/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Anne Arundel Co. MD</b>             |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Ave.</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 29 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                          |   |  |  |



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4  
25M
 BP  
DHMH - 17  
(VR A15 ME (5))

 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 30159

 FOR  
 1- STATE REGISTRAR

|  |                  |   |  |   |   |   |   |  |
|--|------------------|---|--|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Willie Thomas Pearson  |                  |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>MONTH DAY YEAR<br>11-25 1984   |   |   | 2b. HOUR<br>M<br>12:23 p. M                                   |   |  |
| 3. SEX<br>male   | 4. RACE<br>black | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 21 51   | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>33 YRS.                        | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN   | IF UNDER 24 HRS.<br>HOURS MIN   | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>11-25 1984      |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>South Carolina  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hospital - STU |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY            |
| 13a. STATE<br>Md.  |                  |   | 13b. COUNTY  | 13c. CITY OR TOWN<br>Balto.   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 13e. STREET ADDRESS<br>3911 Glenhunt Rd. 21229                |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |                  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Inez   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>yes   |                  |   | 16b. SOCIAL SECURITY NO.<br>212-58-7451                                |   | 17. INFORMANT<br>Inez Irby 3911 Glenhunt Rd. 21229 ADDRESS  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a). Gunshot Wound to Chest (handgun)<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b).<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c).   |                  |   |  |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                  |   |  |   |   |   |   |  |
| 19a. DATE OF OPERATION   |                  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                      |   |   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                  |   | 21b. TIME OF INJURY<br>HOUR XX MONTH DAY YEAR<br>9:31 P.M. 11-25 19 84 |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>subject was shot |   |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>street  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>3900 blk. Glenhunt Road, Balto., Md.         |   |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                  |   |  |   |   |   |   |  |
| ACTUAL SIGNATURE<br><i>Dennis F. Smyth</i>   |                  |   | TITLE (SPECIFY)<br>M.D. Assistant                                      |   |   | DATE SIGNED<br>11-26-84                                       |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Dennis F. Smyth, M.D.  |                  |   | ADDRESS<br>111 Penn St., Balto., Md. 21201                             |   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>burial   |                  |   | 23b. DATE<br>11/30/84  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Garrison Forest Vet. Cem.                                   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Reisterstown, Md.                     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leroy O. Dyett 4600 Liberty Hgts. Ave  |                  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 28 1984  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Fitch Davidson</i>                                 |  |



20% COTTON FIBER

MADE IN U.S.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8430160  
REG. NO.

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH  |  | 2b. HOUR   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | MONTH DAY YEAR   |  | MONTH DAY YEAR   |  |
| FIRST MIDDLE LAST  |  | 11 21 84   |  | 602 AM   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  |
| F  |  | B  |  | MONTH DAY YEAR   |  |
|  |  |  |  | 12 25 1901   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |
| Alabama  |  | U.S.A.   |  | 82 YRS.  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |
| Baltimore  |  | Lutheran Hospital  |  | Baltimore City MD.   |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
|  |  |  |  |  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  |
| Maryland   |  | Baltimore  |  | Baltimore  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  | 13d. STREET ADDRESS  |  |
| FIRST MIDDLE LAST  |  | FIRST MIDDLE LAST  |  | 1781 Mosher St. 21217  |  |
| Laren Bean   |  | Lorraine   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |
|  |  |  |  | Roosevelt Jenkins 1781 Mosher St. 21217  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |
| IMMEDIATE CAUSE (a) Cardiogenic shock  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Acute myocardial infarction   |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.   |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Pulmonary Edema.  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
|  |  | P.M. 19  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |
|  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/21/84 to 11/21/84, that (I) (we) last saw the deceased alive on 11/21/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED   |  |
| BICH T DUONG   |  | M.D.   |  | 11/21/84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |  |
| BICH T DUONG   |  | LUTHERAN HOSPITAL  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| Burial   |  | 11-27-84   |  | Mount Auburn Cemetery  |  |
| 24. FUNERAL DIRECTOR   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  | 23e. DATE REC'D. BY REGISTRAR  |  |
| Vernon R. Bailey   |  | Baltimore Maryland   |  | NOV 27 1984  |  |
| 1348 N. Calhoun St. 21217  |  | 23f. REGISTRAR'S SIGNATURE   |  |  |  |
|  |  | John Davidson-Randall  |  |  |  |

4300 10 13 11

1000 10 13 11

10

10

10



1000 10 13 11

CHIEFLMAN



2000 10 13 11

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8430161

1- FOR  
STATE  
REGISTRAR

|  |  |  |  |   |  |  |   |   |  |   |  |
|--|--|--|--|---|--|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Friedemann Heinrich Bernard Penner</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 19, 1984</b>        |   | 2b. HOUR<br>M<br><b>M</b>  |  |   |   |  |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Apr. 29, 1929</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>55</b> YRS.                                    |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>   |  | 8. IF UNDER 24 HRS.<br>HOURS MIN.<br><b>0 0</b> |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Germany</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |   |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Mercy Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Clergyman</b> |   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| 13a. STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br><b>400 E. Lexington Street 21202</b>   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Bernard Penner</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Reintraut VonSanden</b>   |  |  |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>213-50-7458</b>                         |   | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Hannelies E. M. Penner same as # 13</b>    |  |   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Recent myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary atherosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>15 yrs</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>hours</b> |  |  |  |   |  |  |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>None</b>  |  |  |  |   |  |  |   |   |  |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) |  |   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10-31</b> , 19 <b>84</b> , to <b>11-19</b> , 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>10-31</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |   |   |  |   |  |
| 22b. SIGNATURE<br><b>George C. Rovetti</b>   |  |  |  | DEGREE<br><b>M.D.</b>   |  |  |   | ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/><br>PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>Nov. 19, 1984</b>        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>George C. Rovetti, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>100 N. Broadway Baltimore, Md.</b>   |  |  |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>11/23/84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park Cem.</b>                |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J. Ruck, Inc. Baltimore, Maryland</b>   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 20 1984</b>                                  |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson</b>   |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP  
DHMH - 16 50M 4/83  
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

November 10, 1984

Phone

Philadelphia, PA

1-215-381-1111

November 10, 1984

White

Male

Morey Hospital

1-215-381-1111

1-215-381-1111

1-215-381-1111

1-215-381-1111

1-215-381-1111

1-215-381-1111

12/84

1-215-381-1111

More

1-215-381-1111

1-215-381-1111

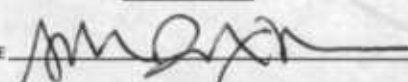
100 N. Broadview Baltimore, Md.

George C. Morey, M.D.

Leonard J. Morey, Inc. Baltimore, Maryland

**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. **30162**

|  |  |               |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                      |  |
|--|--|---------------|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|----------------------|--|
| 1. FOR STATE REGISTRAR   |  |               |  |   |  |  |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 11 23 19 84 |  |  |  |  |  |  |  |  |  | 2b. HOUR a. M. 10:43 |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NELSON T. PENNINGTON, Jr.   |  |               |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                      |  |
| 3. SEX Male  |  | 4. RACE Black |  | 5. DATE OF BIRTH MONTH DAY YEAR 2 13 25   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.                      |  | IF UNDER 1 YR. MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.  |  | 7c. DATE PRONOUNCED DEAD 11 23 19 84   |  | 7d. HOUR a. M. 10:43                         |  |  |  |  |  |                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.  |  |               |  | 7b. CITIZEN OF WHAT COUNTRY? USA  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.                          |  |  |  |  |  |  |  |                      |  |
| 10. CITY OR TOWN OF DEATH Baltimore  |  |               |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1945 N. Collington Ave. |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |  |  |                      |  |
| 13a. STATE Md.   |  |               |  | 13b. COUNTY   |  | 13c. CITY OR TOWN Balto.                                     |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS 21213 1945 N. Collington Ave.                                      |  |  |  |  |  |  |  |  |  |                      |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Nelson T. Pennington, Sr.  |  |               |  |   |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Strother                          |  |  |  |  |  |  |  |  |  |                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes   |  |               |  | 16b. SOCIAL SECURITY NO. WWII 213-30-6094   |  | 17. INFORMANT ADDRESS Mildred Pennington 925 N. Rosedale St. |  |  |  |  |  |  |  |  |  |  |  |  |  |                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |               |  |   |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |  |  |                      |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |               |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                      |  |
| 19a. DATE OF OPERATION   |  |               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |  |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |  |  |                      |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |               |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |  |  |  |  |  |  |  |  |                      |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |               |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |  |  |  |  |                      |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |               |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                      |  |
| ACTUAL SIGNATURE    |  |               |  | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER   |  |  |  |  |  |  |  | DATE SIGNED 11-28-84   |  |  |  |  |  |  |  |                      |  |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.   |  |               |  | ADDRESS 111 Penn St., Balto., Md. 21201   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  |               |  | 23b. DATE 11/29/84  |  | 23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Vet       |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mill, Md.                               |  |  |  |  |  |  |  |  |  |                      |  |
| 24. FUNERAL DIRECTOR NAME Wm C March F/H   |  |               |  | ADDRESS 1101 E. North Ave.  |  |  |  | 25a. DATE REC'D. BY REGISTRAR NOV 29 1984  |  |  |  | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Hendall                                |  |  |  |  |  |  |  |                      |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/B4  
25M

BP

DHMH - 17  
(VR A15 ME (5))



31

20% COTTON FIBER

WOND

WIND



4/2/50

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 3 0 1 6 3  
REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |   |  |   |
|--|--|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JOHN PERILLA</b>                         |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 09, 1984</b>   |  | 2b. HOUR<br><b>10:23AM</b>  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Cauc.</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 8 1933</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>51</b> YRS.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New Jersey</b>                     | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                      | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Schoolteacher</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Education</b>   |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frank Perilla</b>                     |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Tessie Calvell</b>  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b> |  | 16b. SOCIAL SECURITY NO.<br><b>1953-1955</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Robert Perilla 2812 Orleans St.</b>                              |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Adenocarcinoma of common bile duct**

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:

**none**

|  |   |  |  |
|--|---|--|--|
| 19a. DATE OF OPERATION<br><b>March 1984</b>  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>obstructive jaundice</b> | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)          | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |  |  |
| 22b. SIGNATURE<br><b>Joseph M Molina</b>   |   | 22c. DATE SIGNED<br><b>11/9/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Joseph M Molina</b>  |   | 22e. ADDRESS<br><b>Johns Hopkins Hospital Baltimore MD</b>                           |  |

|   |                              |  |  |
|---|------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                          | 23b. DATE<br><b>11/12/84</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cemetery</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>B. Dabrowski &amp; Son 2818 E. Baltimore St.</b> |                              | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 13 1984</b>            | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>         |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Division of Vital Records with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 4 3 0 1 6 4<br>REG. NO.  |  |  |   |
|--|--|--|--|--|--|--|---|
| 1- FOR STATE REGISTRAR   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |  |   |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>ADELAIDE, DEBBY M. Perry  |  |  |  | 2b. HOUR<br>11 26 84 9 30 AM   |  |  |   |
| 3. SEX female  |  | 4 RACE W   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>5 5 1897  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 87   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |
| 13a. STATE Md.   |  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN Balto.   |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>John Blair  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Adelaide ?   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.<br>220-46-6979  |  | 17 INFORMANT ADDRESS<br>816 Wedgewood Rd. - Balto., Md.<br>Patrick Perry #21229  |  |  |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>myocardial infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last                 |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 week</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>CVA</u>  |  |  |  |  |  |  |   |
| 19a. DATE OF OPERATION<br><u>none</u>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE  |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/1</u> , 19 <u>84</u> , to <u>11/26</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>11/25</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |   |
| 22b. SIGNATURE<br><u>John Singer</u>   |  |  |  | DEGREE<br><u>M.D.</u>  |  | 22c. DATE SIGNED<br><u>11/26/84</u>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>John Singer</u>  |  |  |  | 22e. ADDRESS<br><u>900 Caten Ave Balto.</u>  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>   |  | 23b. DATE<br><u>Nov. 29, 1984</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>New Cathedral</u>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><u>Balto. Md.</u>   |   |
| 24. FUNERAL DIRECTOR<br><u>G. Truman Schwab</u>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><u>NOV 28 1984</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |   |
| 25c. ADDRESS<br><u>5151 Balto. Nat'l. Pike #21229</u>  |  |  |  |  |  |  |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  | 8 4 3 0 1 6 5<br>REG. NO.  |  |
|---|--|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Isadore Persky</b>   |  |  |  |   |  |   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR HOUR<br><b>11 13 84 10:02 P.</b>           |  |
| 3 SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br><b>NOV. 13, 1918<sup>AR</sup></b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  | IF UNDER 74 HRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN STATE OF RESIDENCE, GIVE STREET ADDRESS)<br><b>FRANCES SCOTT KEY MED. CENTER</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>NONE</b>                 |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>NONE</b>   |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   |  |   |  |  |  | #21208   |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTO.</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>4 STONEHENGE CIR., APT. 6</b>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HARRY PERSKY</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>JENNIE MILLER</b>   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>216-03-3847C1</b>   |  | 17. INFORMANT<br><b>HARRY L. ROCHESTER</b>  |  |   |  | 4 STONEHENGE CIR., APT. 6 #21208   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Overwhelming Sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Basal infarction</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b><br><b>5 days</b> |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10 Nov</b> 19 <b>84</b> , to <b>13 Nov</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>13 Nov</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Harold G Jackson, MD</b><br>DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |  |  |   |  |   |  |  |  | 22c. DATE SIGNED<br><b>13 Nov 84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Harold G Jackson</b>  |  |  |  | 22e. ADDRESS<br><b>Frances Scott Key Hospital</b>   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>NOV. 15, 1984</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>AHAVAS SHALOM-AGUDAS</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ACHIM ROSEDALE BALTO. MD</b>                   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b><br>ADDRESS<br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |  |  |  | 25a. DATE REC'D BY REGISTRAR<br><b>NOV 20 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Harold G Jackson</b>   |  |  |  |  |  |



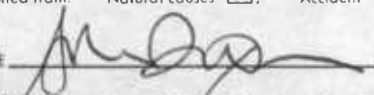
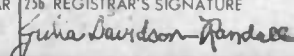


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

30166

|   |  |                                     |  |  |  |   |  |  |  |   |  |          |  |
|---|--|-------------------------------------|--|--|--|---|--|--|--|---|--|----------|--|
| 1- FOR STATE REGISTRAR  |  |                                     |  |  |  |   |  |  |  | 2a. DATE KNOWN OF DEATH   |  | 2b. HOUR |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>FOREST (FORREST) L. PETERSON  |  |                                     |  |  |  |   |  |  |  | MONTH DAY YEAR<br>11 14 19 84   |  | M        |  |
| 3. SEX<br>M   |  | 4. RACE<br>B                        |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>9 18 40   |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN<br>44 YRS.                                  |  | 7c. DATE PRONOUNCED DEAD   |  | 2d. HOUR  |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City  |  | MD   |  | 11 14 19 84 1:06 a.m.   |  |          |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  |                                     |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Johns Hopkins Hospital                        |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |          |  |
| 13a. STATE<br>MD  |  |                                     |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>823 Glover St. 21205   |  |          |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Randolph Peterson  |  |                                     |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Louise Cooley                                       |  |  |  |   |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>No  |  |                                     |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS<br>Sam Cooley 3936 Lowndes Avenue   |  |  |  |   |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Stab wounds of abdomen</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |                                     |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |                                     |  |  |  |   |  |  |  |   |  |          |  |
| 19a. DATE OF OPERATION  |  |                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>          |  |   |  |          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                                     |  | 21b. TIME OF INJURY HOUR MIN MONTH DAY YEAR<br>11:30 a.m. 11-13-1984   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Subject stabbed. |  |  |  |   |  |          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |                                     |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>street  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE<br>800 blk. N. Luzerne Ave., Balto. City, Md.             |  |  |  |   |  |          |  |
| 22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                                     |  |  |  |   |  |  |  |   |  |          |  |
| ACTUAL SIGNATURE   |  |                                     |  |  |  | TITLE (SPECIFY)<br>M.D. Assistant   |  | MEDICAL EXAMINER   |  | DATE SIGNED 11-14-84  |  |          |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Ann M. Dixon, M.D.   |  |                                     |  |  |  | ADDRESS 111 Penn St., Balto., Md. 21201   |  |  |  |   |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |                                     |  | 23b. DATE<br>11/20/84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Peterson Family Cem.  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Chesterfield Co. VA                               |  |   |  |          |  |
| 24. FUNERAL DIRECTOR NAME<br>Wm. C. March F/H, Inc.   |  |                                     |  |  |  | ADDRESS<br>1101 E. North  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 19 1984   |  | 25b. REGISTRAR'S SIGNATURE<br> |  |          |  |

211813 10/10/00 6/00

10/10/00

10/10/00



10/10/00

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8430167  
REG. NO.

1 - FOR  
STATE  
REGISTRAR

|  |  |   |   |  |                                   |
|--|--|---|---|--|-----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | 2a. DATE OF DEATH   |   | 2b. HOUR   |                                   |
| James Pettigrew  |  | 11-19-84  |   | 5:15 PM  |                                   |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | 7. IF UNDER 1 YEAR   |                                   |
| male   | Black  | 11 4 1915   | 69  | MONTHS DAYS HOURS MIN.   |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                   |
| N. Carolina  | U.S.A.   |   | BALTO. City MD.   |  |                                   |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY |
| Balto City   | Greater Penn Nursing Center  |   |   |  |                                   |
| 13a. STATE   | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS  |                                   |
| MD   |  | BALTO.  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 475 Stockton St. 21223   |                                   |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME  |   |  |                                   |
| James Pettigrew  |  | Unknown   |   |  |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)   |  | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS  |                                   |
| Unknown  |  | 249-26-2219   |   | Emma Hudson 475 Stockton St. 21223   |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cancer of Pancreas</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 months.</u> |  |   |   |  |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Arteriosclerosis, Atrial Fibrillation</u>  |  |   |   |  |                                   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?  |                                   |
|  |  |   |   | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11-9-1984</u> to <u>11-19-1984</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  | 22b. SIGNATURE<br><u>Suman M.D.</u>   |   | 22c. DATE SIGNED<br><u>11-21-84</u>  |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |   |  |                                   |
| SHAIKAT Y. KHAN  |  | 1528 King W. Ch. and Ave. N. Balto MD   |   |  |                                   |
| 23a. BURIAL, CREMATION, REMOVAL  | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY  | 23d. LOCATION   |  |                                   |
| Burial   | 11-24-84   | Mt Auburn   | Balto MD  |  |                                   |
| 24. FUNERAL DIRECTOR<br>NAME   |  | 25. DATE REC'D BY REGISTRAR   |   | 26. REGISTRAR'S SIGNATURE  |                                   |
| Lavin P. Carroll   |  | NOV 23 1984   |   | [Signature]  |                                   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8430168<br>REG. NO.   |  |   |   |                          |
|--|--|---|--|---|--|---|---|--------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MOSES PFAU</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11-7-84</b>  |  |   |   | 2b. HOUR<br><b>442PM</b> |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 22 96</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS.   |   |                          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>POLAND</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |  |   |   |                          |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b> |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>NONE</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>NONE</b>  |   |                          |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b> 13b. COUNTY <b>XXXXX</b> 13c. CITY OR TOWN <b>BALTIMORE</b>  |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>7120 PARK HTS. AVE.</b><br><b>21215</b>   |   |                          |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN PFAU</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>   |  |   |   |                          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>2A 64 8593</b>   |  | 17. INFORMANT <b>HEBREW BURIAL &amp; SOC. SERV. SOCIETY</b><br><b>9 W. MULBERRY ST. BALTO., MD 21201</b>  |  |   |   |                          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>SEPSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Necrotic Bowel</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypotension 2° to A MI</b>   |  |   |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |                          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Renal Failure, COPD, metastatic Prostatic Ca</b>   |  |   |  |   |  |   |   |                          |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |                          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)  |  |   |   |                          |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |                          |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-4-84</b> to <b>11-7-84</b> , that (I) (we) last saw the deceased alive on <b>11-7-84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |   |                          |
| 22b. SIGNATURE<br><b>Jeffrey M. Mocc</b><br>22b. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11-7-84</b>  |   |                          |
| 22d. ADDRESS<br><b>JEFFREY M. Mocc</b>   |  |   |  | 22e. ADDRESS<br><b>SINAI HOSP. - BALTO., MD</b>   |  |   |   |                          |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>NOV. 8, 1984</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE HEBREW</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>   |   |                          |
| 24. FUNERAL DIRECTOR<br>NAME <b>SOL LEVINSON &amp; BROS., INC.</b><br>ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 13 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Lia Bairden-Rendell</b>  |   |                          |





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8430169  
REG. NO.1- FOR  
STATE  
REGISTRAR

|   |  |   |  |   |  |   |   |  |  |
|---|--|---|--|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>KATHRYN MARY Phillips  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 20 84                        |   |  | 2b. HOUR<br>802A M  |   |  |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 11 99  |  | 6. AGE (IN YEARS, [AS] BIRTHDAY)<br>85 YRS  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Meridan Nursing Center |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>housewife                   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |  |   |   |  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Howard   |  | 13c. CITY OR TOWN<br>Elkridge   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br>6754 Montgomery Road, 21227  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Godfrey Felty   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Florence Shipley   |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>no  |  |   |  | 16b. SOCIAL SECURITY NO.<br>214 24 6475   |  | 17. INFORMANT<br>ADDRESS<br>Isabelle Wilford 6754 Montgomery Rd. Elkridge, Md. 21227            |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCD ch Bronchitis</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a  |  |   |  |   |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Oct. 80</u> to <u>Nov. 20</u> , 19 <u>84</u> , that (I) (we) lost<br>saw the deceased alive on <u>November 20</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.          |  |   |  |   |  |   |   |  |  |
| 22b. SIGNATURE<br><u>Seenivasan</u>   |  |   |  | DEGREE<br>MD<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |   |   | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SEENIVASAN   |  |   |  | 22e. ADDRESS<br>606 Hammond Lane, BALTO, 21225  |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>burial  |  |   | 23b. DATE<br>11/24/84  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Mem. Pk.                     |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Elkridge Howard Md. |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Kaufman Funeral Home 5695 Main St. Elkridge, Md. 21227  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 21 1984  |  | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Russell   |   |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of such.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

84 30170  
REG. NO.

|  |  |  |   |  |  |
|--|--|--|---|--|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH  |   | 2b. HOUR   |  |
| DECEASED NAME (TYPE OR PRINT)  |  | MONTH DAY YEAR   |   | HOUR MIN.  |  |
| Leroy  |  | 11/26/84   |   | 9:40 PM  |  |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH   |   | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |
| Male   | BLACK  | MONTH DAY YEAR   |   | YRS MONTHS DAYS HOURS MIN.   |  |
|  |  | 1 1 30   |   | 54   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |
| Maryland   | U.S.   |  |   | Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |
| Baltimore  | Provident Hosp.  |  |   |  |  |
| 13a. STATE   |  | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?   | 13e. STREET ADDRESS / ZIP CODE                                 |
| Md.  | --   | Balto.   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 1136 Gilmore St. 21217   |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME  |  |  |
| FIRST MIDDLE LAST  |  |  | FIRST MIDDLE LAST   |  |  |
| Lee Willie Phillips  |  |  | Dorothy Williams  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   | 17. INFORMANT ADDRESS   |  |  |
| Unkn.  |  | 217-26-8072  | Margaret P. Owens 904 Scotthill Dr. 21208                           |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |
| IMMEDIATE CAUSE (a) Cardio Pulmonary Arrest  |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac (Myocardial Infarction)   |  |  |   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|  |  |  |   | YES <input type="checkbox"/> NO <input type="checkbox"/>                       | YES <input type="checkbox"/> NO <input type="checkbox"/>       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |   |  |  |
|  |  | P.M. 19  |   |  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION  |  |
| WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>  |  |  |   | STREET CITY OR TOWN COUNTY STATE   |  |
| AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |   |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 11/26, 19 84, to 11/26, 19 84, that (I) (we) last saw the deceased alive on 11/26, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |
| 22b. SIGNATURE   |  | DEGREE   |   | 22c. DATE SIGNED   |  |
| Eleanor Y. Hixon, MD   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |   | 11/26/84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |   |  |  |
| Eleanor Y. Hixon, MD   |  | 3100 TOWANDA AVE   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY                                  |  | 23d. LOCATION  |
| Burial   |  | 12/17/84   | Mt. Zion Cemetery   |  | CITY OR TOWN COUNTY STATE                                      |
|  |  |  |   |  | Landsdown, Md.   |
| 24. FUNERAL DIRECTOR   |  |  |   |  |  |
| NAME ADDRESS   |  |  |   |  |  |
| Joseph E. Russ 2222 W. NORTH AVE. Balto., Md.  |  |  |   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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11/2/11  
[Faint, mostly illegible handwritten text follows, appearing to be a list or notes on lined paper.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 3 0 1 7 1

REG. NO.

|   |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Mary Edna Phillips</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 9, 1984</b>         |   |  | 2b. HOUR<br>M<br><b>AM</b>  |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 15, 1900</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3645 Chestnut Avenue</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Md</b>   |  | 13b. COUNTY<br><b>--</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>3645 Chestnut Avenue 21211</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joshua Hyle</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary --</b>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>212 36 8868</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Donald C. Smith 1800 Downsville Pike 21740</b>                   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ASCVD</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Diabetes</b> |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Immediate</b><br><b>4 hrs</b><br><b>years</b>                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>---</b>   |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |  |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>1982</b> 19 <b>11/8</b> 19 <b>84</b> , that (2) we last saw the deceased alive on <b>10/29/84</b> 19 <b>---</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (3) we (did) (did not) view the body after death.                              |  |  |  |   |  |   |  |  |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Richard Diamond</b>   |  |  |  |   | 22c. DATE SIGNED<br><b>11/12/84</b>  |   |  | 22d. ADDRESS<br><b>3547 Chestnut Avenue 21211</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>11/13/84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Monkton M. E. Cemetery</b>            |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Co. Md</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Burgee-Henss Funeral Home</b>  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 13 1984</b>                            |   |  |  |  |
| ADDRESS<br><b>3631 Falls Rd. 21211</b>  |  |  |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                    |   |  |  |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| FOR<br>1. STATE<br>REGISTRAR   |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 4 3 0 1 7 2<br>REG. NO.  |                                  |  |  |
|--|--|--|--|--|--|--|--|--|----------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ANNIE BELL Pilgrim  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11-4-84   |  |  |  | 2b. HOUR<br>7:40 AM  |                                  |  |  |
| 3 SEX<br>FEMALE  |  | 4 RACE<br>Black  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>11 17 05  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |                                  | IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>South Carolina   |  | 7b CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                       |  |  |                                  |  |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Lutheran Hospital |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  |  | 12b KIND OF BUSINESS OR INDUSTRY |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |  |  |  |  |  |                                  |  |  |
| 13a STATE<br>Md.   |  | 13b COUNTY   |  | 13c CITY OR TOWN<br>Baltimore  |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET ADDRESS<br>2530 Arunah Ave                                    |                                  |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Cook   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Nannie Garrett  |  |  |  |  |                                  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES]<br>No  |  |  |  | 16b SOCIAL SECURITY NO.<br>212-26-4652   |  | 17 INFORMANT ADDRESS<br>Mattie Houston 2530 Arunah Ave.  |  |  |                                  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Anoxic encephalopathy</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Bilateral pneumonia -</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cachexia</u><br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Dementia Sept 83</u> |  |  |  |  |  |  |  |  |                                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| 19a DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                 |  |  |                                  |  |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |                                  |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from <u>10-2</u> 19 <u>84</u> to <u>11-4</u> 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>11-4</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |  |  |                                  |  |  |
| 22b SIGNATURE<br><u>S. S. S. S. S.</u>   |  |  |  | DEGREE<br>M ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>     |  |  |  | 22c. DATE SIGNED<br>11-4-84  |                                  |  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>Sissay Awoke   |  |  |  | 22e ADDRESS<br>Lutheran Hospital   |  |  |  |  |                                  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |  |  | 23b. DATE<br>11-10-84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Church Cemetery  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>Greensville S. Carolina     |                                  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H 1101 E. North Ave.   |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 8 1984  |  | 25b. REGISTRAR'S SIGNATURE<br><u>John Davidson-Randall</u>               |                                  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 367-1234.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

84 30173

REG. NO.

|  |   |   |  |   |  |
|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>NORMAN</b> <b>PLUMMER, JR.</b>  |   |   | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>4</b> YEAR <b>84</b> |   | 2b. HOUR<br><b>9:45 AM</b>   |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>BLACK</b>   | 5. DATE OF BIRTH<br>MONTH <b>6</b> DAY <b>22</b> YEAR <b>41</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>43</b> YRS                 |   | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>N.Y.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY</b> MD.          |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Frances Scott Key Medical</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>MD</b>  |   | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>1713 E. 25th St. 21213</b>   |
| 14. FATHER'S NAME<br>FIRST <b>Norman</b> MIDDLE <b></b> LAST <b>Plummer Sr.</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Geanev</b> MIDDLE <b></b> LAST <b>Pearson</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>216-36-7237</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Ynetha Plummer 1713 E. 25th St.</b>                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of Esophagus</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |   |   |  |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |   |   |  |   |  |
| 22b. SIGNATURE<br><b>J. B. Smith</b>   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>11/3/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |   | 22e. ADDRESS  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>11/9/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cem.</b>                                     |  |
| 23d. LOCATION<br>CITY OR TOWN<br><b>Baltimore</b>  |   | COUNTY<br><b>MD</b> STATE   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 7 1984</b>               |   |  |
| ADDRESS<br><b>1101 E. North Ave.</b>   |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>J. Davidson-Randall</b>         |   |  |

Handwritten notes at the top of the page, including the word "Lecture" and some illegible scribbles.



Main body of handwritten notes, appearing as a list or series of entries, with some words like "Lecture" and "Notes" visible.

Handwritten notes at the bottom of the page, including the word "Lecture" and some illegible scribbles.

FOR  
STATE  
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 3 0 1 7 4

REG. NO.

|   |  |  |  |   |  |   |   |  |  |  |
|---|--|--|--|---|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Annie Point</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 29 84</b>                 |   |  | 2b. HOUR<br>M<br><b>AM</b>  |   |  |  |  |
| 3. SEX<br><b>female</b>   |  | 4. RACE<br><b>black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 28 27</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>57</b> YRS.                         |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore city</b> MD.         |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>909 E. 37th Street</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)          |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md</b>  |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>909 E. 37th St. 21218</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Pringle Sr.</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Annie Pringle</b>   |  |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES<br><b>No</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>577-34-1408</b>                         |   | 17. INFORMANT<br>ADDRESS<br><b>Frank Point 1830 W. Fayette St.</b>             |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio resp. arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Dehydration</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>metastatic cancer</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a |  |  |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>immediate</b>   |  |  |
|   |  |  |  |   |  |   |   | <b>3 months</b>  |  |  |
|   |  |  |  |   |  |   |   | <b>1 1/2 yrs</b>   |  |  |
|   |  |  |  |   |  |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Dec. 22, 1983</b> , to <b>Nov. 29, 1984</b> , that (I) (we) last saw the deceased alive on <b>Nov. 2, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.   |  |  |  |   |  |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Albert L. Blumberg MD</b>  |  |  |  |   |  | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>4/30/84</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Albert L. Blumberg MD</b>   |  |  |  |   |  | 22e. ADDRESS<br><b>6701 N. Charles St Baltimore 21204</b>                 |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>12/5/84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Forest VA</b>                |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Owings Mills MD</b>                            |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>William C. March F/H 1101 E. North Ave</b>   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 4 1984</b>                        |   | 25b. REGISTRAR'S SIGNATURE<br><b>Jana Davidson-Randall</b>   |  |  |

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 must be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 84 30175   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Jack Polen</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>11 27 84</b>  |  |   |   |
| 3. SEX <b>MALE</b>   |  |  |  | 2b. HOUR <b>11 P.M.</b>   |  |   |   |
| 4. RACE <b>W HITE</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>8 17 17</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENNSYLVANIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> CITY MD.  |   |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sinai Hosp</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MANUFACTURER REP.</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>MENS CLOTHING</b>  |   |
| 13a. STATE <b>MD</b>   |  | 13b. COUNTY <b>BALTIMORE</b>   |  | 13c. CITY OR TOWN <b>BALTIMORE</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM POLEN</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LILLIAN GUBIN</b>  |  | 13e. STREET ADDRESS <b>3117 Northbrook Rd 21208</b>   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>  |  | 16b. SOCIAL SECURITY NO. <b>197-10-6780</b>  |  | 17. INFORMANT <b>MRS. MYRA POLEN</b>  |  |   |   |
|  |  |  |  | <b>3117 NORTHBROOK RD. BALTO., MD 21208</b>   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Lung carcinoma</b>   |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b> |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |   |   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |   |  |   |   |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |   |   |
| (c)  |  |  |  |   |  |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a   |  |  |  |   |  |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |   |
| 22b. SIGNATURE <b>R. Zuckerman</b>   |  | DEGREE <b>MD</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>    |  | 22c. DATE SIGNED <b>11/27/84</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R. Zuckerman MD</b>   |  | 22e. ADDRESS <b>Sinai Hosp</b>   |  |   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |  | 23b. DATE <b>NOV. 29, 1984</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>HAR SINAI</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>OWINGS MILLS BALTO. MD</b>   |   |
| 24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b> ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>DEC 3 1984</b> REGISTRAR'S SIGNATURE <b>John Davidson</b>  |  |   |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be mailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states still injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/83  
(VRA 15, 4)

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

84 30176

REG. NO.

|   |  |   |   |   |  |   |  |   |  |
|---|--|---|---|---|--|---|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>CLIFTON Wilgus POORE</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 18, 1984</b> |   |  | 2b. HOUR<br><b>3:40 P.M.</b>  |  |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 14 1909</b>   |  | 6. AGE<br>(LAST BIRTHDAY)<br><b>X 75</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Tenn.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Mill worker</b>          |  | 12b. KIND OF BUSINESS OR INDUSTRY                                 |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD.</b> 13a. COUNTY <b>Balto.</b> |  |   |   | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>9027 Old Court Rd. 21207</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Elliott W. Poore</b>   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth</b>   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>411-18-6292</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Thomas Hawes 9027 Old Court Rd.</b>  |  |   |  |   |  |

MEDICAL CERTIFICATION

|  |  |   |  |
|--|--|---|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| DUE TO, OR AS A CONSEQUENCE OF<br><b>CANCER OF THE LUNG</b>  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |
| (c)  |  |   |  |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (d)

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                        |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>OCTOBER 28, 19 84</b> , to <b>NOVEMBER 18, 19 84</b> , that (I) (we) lost saw the deceased alive on <b>NOVEMBER 18, 19 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did, did not) view the body after death. |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><i>Mukesh Luhar</i>  |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MUKESH LUHAR M.D.</b>  |  | 22e. ADDRESS<br><b>CHURCH HOSPITAL CORPORATION<br/>100 NORTH BROADWAY BALTIMORE, MD 21231</b> |  |  |  |  |  |

|  |  |                              |  |  |  |   |  |
|--|--|------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>        |  | 23b. DATE<br><b>11-22-84</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Red Hill Cem.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Andersonville Anderson Tenn.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>John M. Weber &amp; Sons Inc.</b> |  |                              |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 21 1984</b>        |  | 25b. REGISTRAR'S SIGNATURE<br><i>Jane Davidson</i>                                |  |
| 25c. ADDRESS<br><b>401 S. Chester St.</b>                            |  |                              |  |  |  |   |  |





11/11/11

20% COMMISSION

11-11-11

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

84 30177

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |   |   |   |  |
|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JEAN A. POSTER</b>   |   | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>7</b> YEAR <b>84</b>  |   | 2b. HOUR<br><b>4:30 P.M.</b>   |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH<br>MONTH <b>3</b> DAY <b>25</b> YEAR <b>57</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>27</b> YRS.                                    |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Annapolis Md.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>North Charles General</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>Md.</b>  | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Balto.</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>1904 McCulloh St. 21217</b>                                |
| 14. FATHER'S NAME<br>FIRST <b>Joseph</b> MIDDLE LAST  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b> (IF YES, GIVE WAR OR DATES)  |   | 16b. SOCIAL SECURITY NO. <b>218-74-8848</b>   |   |  |
| 17. INFORMANT   |   | ADDRESS<br><b>Virginia Reynolds 1904 McCulloh St.</b>   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ANOXIC ENCEPHALOPATHY</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ASPIRATION PNEUMONIA + ARDS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ACUTE RENAL FAILURE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><b>Schizophrenia</b>  |   |   |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/26</b> 19 <b>84</b> to <b>11/7</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>11/7</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.   |   |   |   |  |
| 22b. SIGNATURE<br><b>A.E. Chouvalit, M.D.</b>   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   | 22c. DATE SIGNED<br><b>11/7/84</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A.E. CHOUVALIT, M.D.</b>  |   | 22e. ADDRESS<br><b>NORTH CHARLES GEN. HOSP.</b>   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |   | 23b. DATE<br><b>11/12/84</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cem.</b>                                     |  |
| 23d. LOCATION<br>CITY OR TOWN<br><b>Baltimore Md.</b>   |   | 23e. STATE<br><b>Md.</b>  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>   |   | ADDRESS<br><b>1101 E. North Ave.</b>  |   | 25. DATE RECEIVED BY REGISTRAR<br><b>NOV 9 1984</b>                                  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |                  |   |  | 8 4 3 0 1 7 8<br>REG. NO.   |  |  |  |                       |
|--|------------------|---|--|---|--|--|--|-----------------------|
| 1. DECEASED NAME (TYPE OR PRINT)<br>John H. Powell   |                  |   |  | 2a. DATE OF DEATH<br>11 8 84  |  |  |  | 2b. HOUR<br>8:30 P.M. |
| 3. SEX<br>Male   | 4. RACE<br>Black | 5. DATE OF BIRTH<br>1 5 02  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82   |  | # UNDER 1 YEAR<br>MONTHS DAYS  |  |                       |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Frederick, Md   |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |                       |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Provident Hospital. |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                       |
| 13a. STATE<br>Md.  |                  | 13b. COUNTY<br>Balto  |  | 13c. CITY OR TOWN<br>Balto  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |                       |
| 14. FATHER'S NAME<br>John  |                  | 15. MOTHER'S MAIDEN NAME<br>Clara   |  | 13e. STREET ADDRESS / ZIP CODE<br>3505 Woodland Ave. 21215  |  |  |  |                       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |                  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br>Cherry Powell-3505 Woodland Ave.   |  |  |  |                       |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Dehydration</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of Colon with metastasis</u> |                  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>no</u>   |                  |   |  |   |  |  |  |                       |
| 19a. DATE OF OPERATION   |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |                       |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |                       |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/5/84</u> to <u>11/8/84</u> , that (I) (we) lost saw the deceased alive on <u>11/8/84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |                  |   |  |   |  |  |  |                       |
| 22b. SIGNATURE<br><u>Belldah</u>   |                  |   |  | DEGREE<br>MD  |  | 22c. DATE SIGNED   |  |                       |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>PADMAJA S. UDAPATY.   |                  |   |  | 22e. ADDRESS<br>Provident Hospital, 2600 Liberty Heights Baltimore MD 21215   |  |  |  |                       |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |                  | 23b. DATE<br>11/13/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn Cem.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto., Md   |  |                       |
| 24. FUNERAL DIRECTOR<br>Leroy D. Dwyer   |                  |   |  | 25. DATE REC'D BY REGISTRAR<br>NOV 13 1984  |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |  |                       |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8430179

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |   |
|---|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>F</b><br><b>HUGH L. PREAS</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 30, 1984</b>                    |   | 2b. HOUR<br><b>3:49<sup>M</sup></b>                                       |
| SEX<br><b>Male</b>  | 4. RACE<br><b>Caucasian</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 27, 1907</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.           |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Tennessee</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Dentist</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Tennessee</b>  |  | 13b. COUNTY<br><b>Washington</b>  | 13c. CITY OR TOWN<br><b>Johnson City</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>J. H. Preas</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Nannie Bushong</b>  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW 11 411-56-2635</b>   |  | 17. INFORMANT<br>Mrs. Lucy Preas<br><b>1301 Buffalo Street Johnson City, Tenn.</b>              |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAL FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>EXTENSIVE MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 D</b><br><b>12 D</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:1a<br><b>RENAL FAILURE / PNEUMONIA</b>  |  |   |  |   |   |
| 19a. DATE OF OPERATION<br><b>11-28-84</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>UNSTABLE ANGINA POST-MI</b>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)    |  |   |   |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-21</b> , 19 <b>84</b> , to <b>11-30</b> , 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>11-30</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.       |  |   |  |   |   |
| 22b. SIGNATURE<br><b>R. Scott Stuart</b>  |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>11-30-84</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R. Scott Stuart MD</b>  |  | 22e. ADDRESS<br><b>600 N. WOLFE ST. BALTO. MD.<br/>JOHNS HOPKINS HOSP. - PLACER 618</b>   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>12/2/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Monavista Cemetery</b>                                 |   |
| 23d. LOCATION<br>(CITY OR TOWN)<br><b>Johnson City, Washington TENN</b>   |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Boring Byers Funeral Directors, Inc.<br/>8728 Liberty Road Randallstown, MD. 21133</b>                           |  |   |   |
| 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 3 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>na [Signature]</b>   |  |   |   |





HMH - 16 50M 4/83  
(VRA 15, 4)

White

2/1/68

John G. Miller, Jr. 1000 W. 10th St. Omaha, Neb. 68102

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 4 3 0 1 8 1  
REG. NO.

|   |  |  |  |   |                                   |   |   |  |  |
|---|--|--|--|---|-----------------------------------|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>BENNIE E PRICE</b> |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 03 84</b>               |   |                                   | 2b. HOUR<br><b>12:44 P.M.</b>   |   |  |  |
| 3. SEX<br><b>m</b>  |  | 4. RACE<br><b>B</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 - 6 - 1917</b>  |                                   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b>  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>VA.</b>                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore city</b> MD.                       |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>city</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BON Secours Hosp</b> |  |   |                                   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>TRUCK DRIVER</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY                                  |  |
| 13a. STATE<br><b>md</b>   |  |  | 13b. COUNTY<br><b>BALTO</b>  |   | 13c. CITY OR TOWN<br><b>BALTO</b> |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 13e. STREET ADDRESS / ZIP CODE<br><b>905 W. BARRE ST 21201</b>                    |  |  |  |   |                                   |   |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JAMES PRICE</b>                      |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>AMANDA PRICE</b> |   |                                   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)              |  |  | 16b. SOCIAL SECURITY NO.<br><b>228-05-0386</b>                       |   |                                   | 17. INFORMANT<br>ADDRESS<br><b>LOUISE PRICE WF 905 W. BARRE ST</b>                      |   |  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**Cardiac arrest**

DUE TO, OR AS A CONSEQUENCE OF

**Cerebral Vascular DISEASE**

(b)

**Renal FAILURE**

DUE TO, OR AS A CONSEQUENCE OF

**HEART FAILURE**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)


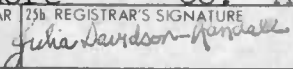
|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from<br>saw the deceased alive on <b>11/3</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (do not) view the body after death. |  | 22b. SIGNATURE<br><b>Kuang-Yen Huang</b> M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/3/84</b>   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KUANG-YEN HUANG</b>   |  | 22e. ADDRESS<br><b>BON Secours Hospital</b>  |  |  |  |   |  |

|   |  |                                      |  |   |  |  |  |
|---|--|--------------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b> |  | 23b. DATE<br><b>11-8-1984</b>        |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Criminville VA</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Criminville md.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Brian Thompson</b>         |  | 24b. ADDRESS<br><b>1913 W. BALTO</b> |  | 25a. DATE REC'D. BY REGISTRAR<br><b>11/8/84</b>             |  |  |  |

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                         |  |   |  |  |  |   |  |   |  | REG. NO. 30182  |  |                          |  |
|--|--|-------------------------|--|---|--|--|--|---|--|---|--|---|--|--------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>CLAYTON D. PRICE</b>   |  |                         |  |   |  |  |  |   |  |   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>11-30-84</b> |  | 2b. HOUR<br><b>11:15</b> |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 27 70</b>   |  | 6. AGE IN YEARS<br>(LAST BIRTHDAY) MONTHS DAYS HOURS MIN<br><b>13 YRS.</b>                           |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>11-30-84</b>   |  | 2d. HOUR<br><b>11:15</b>  |  |   |  |                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>                       |  |   |  |                          |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |                          |  |
| 13a. STATE<br><b>MD</b>  |  |                         |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>30 Upmanor Rd, 21229</b>                                  |  |   |  |                          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>David Price</b>   |  |                         |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Iris Sheridan</b>                                |  |   |  |   |  |   |  |                          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) IF YES, GIVE WAR OR DATES<br><b>No</b>   |  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>N/A</b>  |  | 17. INFORMANT ADDRESS<br><b>David Price 30 Upmanor Rd.</b>   |  |   |  |   |  |   |  |                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>9229 IMMEDIATE CAUSE (a) Gunshot wound of abdomen</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |                         |  |   |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |                          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                         |  |   |  |  |  |   |  |   |  |   |  |                          |  |
| 19a. DATE OF OPERATION   |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |                          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>11-30-84</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)<br><b>subject shot</b> |  |   |  |   |  |   |  |                          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK  |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>home</b>  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>30 Up Manor Road Baltimore, Maryland</b>     |  |   |  |   |  |   |  |                          |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |                         |  |   |  |  |  |   |  |   |  |   |  |                          |  |
| ACTUAL SIGNATURE<br>   |  |                         |  | D. <b>Deputy Chief</b> MEDICAL EXAMINER   |  |  |  |   |  | DATE SIGNED <b>12-1-84</b>  |  |   |  |                          |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Thomas D. Smith, M.D.</b>  |  |                         |  | ADDRESS<br><b>111 Penn Street</b>   |  |  |  |   |  |   |  |   |  |                          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |                         |  | 23b. DATE<br><b>12/4/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk.</b>  |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co. MD</b>               |  |   |  |                          |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Ave.</b>   |  |                         |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 4 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br>   |  |   |  |   |  |                          |  |



1 2


STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

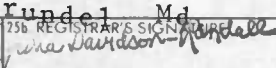
REC. NO. 30183

1- FOR  
STATE  
REGISTRAR

|  |                         |  |  |  |  |   |  |  |  |
|--|-------------------------|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MARLENE PRIOLEAU</b>                     |                         |  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>11 7 19 84</b>   |  |   |  | 2b. HOUR<br>M<br><b>1:30</b>                           |  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>Balck</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 10 64 20</b>   | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>MONTHS DAYS HOURS MIN.<br><b>20 YRS.</b> | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>11 7 19 84</b>                                 |  | 7d. HOUR<br>M<br><b>1:30</b>                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto. Md.</b>                     |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                      |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Darley Ave. &amp; Wolfe St.</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY                      |  |
| 13a. STATE<br><b>Md.</b>   |                         | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Balto.</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3133 Ravenwood Ave 21213</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Lloyd Prioleau</b>                    |                         |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Fannie Branch</b>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b> |                         | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>220-80-3709</b>  |  | 17. INFORMANT ADDRESS<br><b>Lloyd Prioleau 2323 Ashland Ave.</b>   |  |   |  |  |  |

|  |  |  |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gunshot wound of neck (unspecified weapon)</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u><br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|--|

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>1:15x 11-7- 84</b>     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br><b>Subject shot.</b>     |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>street</b> |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>Darley Ave. &amp; Wolfe St., Balto. City, Md.</b> |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |   |  |
| ACTUAL SIGNATURE<br>  |  | TITLE (SPECIFY)<br><b>Assistant</b> M.D.                                     |  | MEDICAL EXAMINER<br>DATE SIGNED <b>11-7-84</b>  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Ann M. Dixon, M.D.</b>  |  | ADDRESS <b>111 Penn St., Balto., Md. 21201</b>                               |  |   |  |

|  |  |                              |  |  |  |   |  |
|--|--|------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                      |  | 23b. DATE<br><b>11-10-84</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cem.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Anne Arundel Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Ave.</b> |  |                              |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 8 1984</b>           |  | 25b. REGISTRAR'S SIGNATURE<br> |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IN EXECUTING THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITHIN 2 HOURS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



COLLIERIES

WIND



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 30184

FOR  
STATE  
REGISTRAR

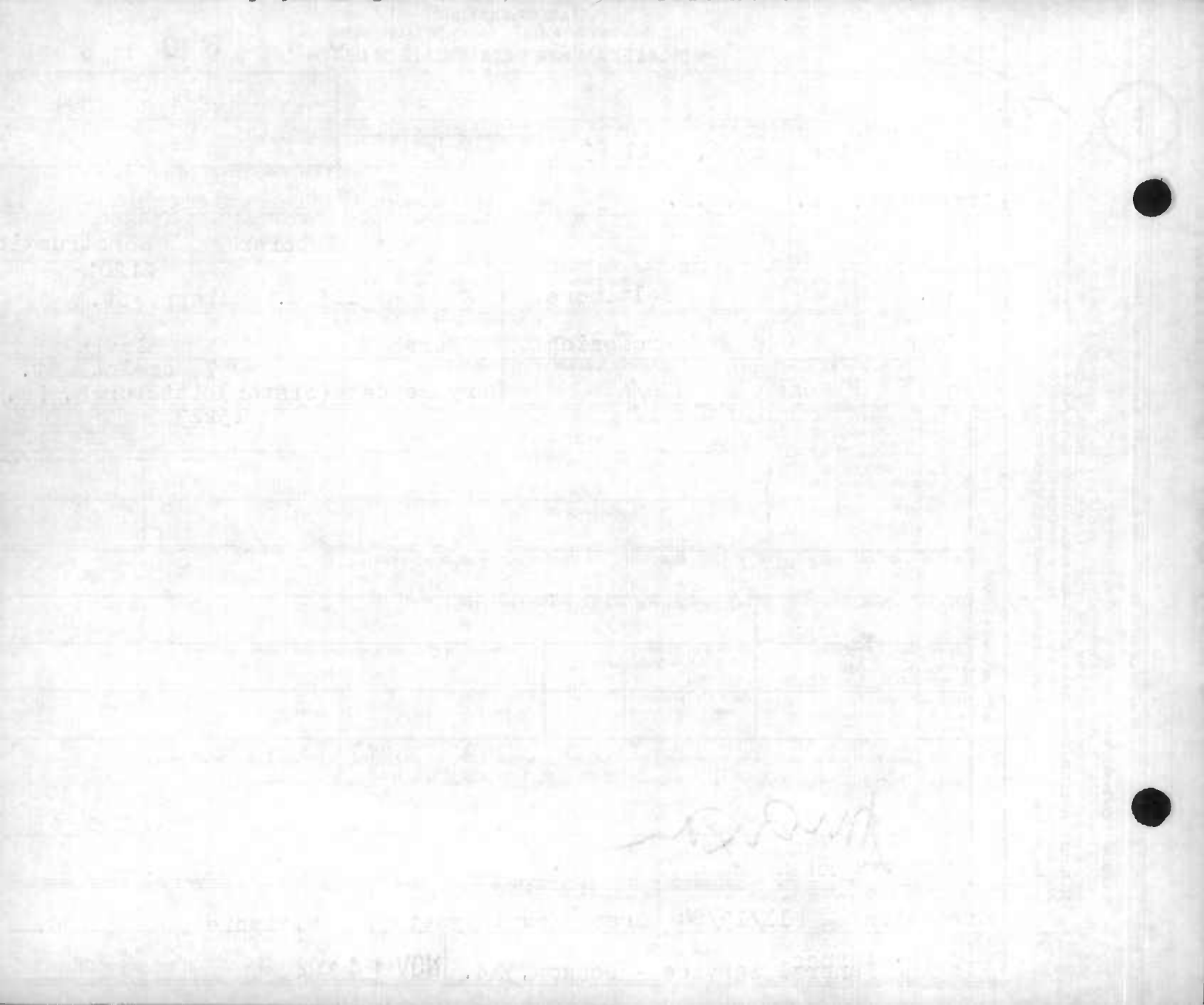
|   |         |  |  |  |  |   |  |  |  |  |  |       |  |      |  |           |  |
|---|---------|--|--|--|--|---|--|--|--|--|--|-------|--|------|--|-----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         | FIRST  |  | MIDDLE   |  | LAST  |  | 2a. DATE KNOWN OF DEATH  |  | MONTH  |  | DAY   |  | YEAR |  | 2b. HOUR  |  |
| RUDOLPH   |         |  |  |  |  | PROFOZICH   |  | ESTIMATED  |  | 11   |  | 9     |  | 1984 |  |           |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)  |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.   |  | 7c. DATE PRONOUNCED DEAD                     |  | MONTH |  | DAY  |  | YEAR      |  |
| Male  | White   | May 6, 1921  |  | 63 YRS.  |  |   |  |  |  | 11   |  | 10    |  | 1984 |  | 9:47 a.m. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |  |  |       |  |      |  |           |  |
| Pittsburgh, Pa.   |         | U.S.A.   |  |  |  | Baltimore City  |  |  |  |  |  |       |  |      |  |           |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |  |  |       |  |      |  |           |  |
| Baltimore   |         | 115 W. Mulberry St.  |  | Laborer  |  | Construction  |  |  |  |  |  |       |  |      |  |           |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |         | 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS                          |  |       |  |      |  |           |  |
| Md.   |         |  |  | Baltimore  |  |   |  |  |  | 115 W. Mulberry St.                          |  |       |  |      |  |           |  |
| 14. FATHER'S NAME   |         | MIDDLE   |  | LAST   |  | 15. MOTHER'S MAIDEN NAME  |  | MIDDLE   |  | LAST   |  |       |  |      |  |           |  |
| John  |         |  |  | Profozich  |  | Sarah   |  |  |  | Slavka                                       |  |       |  |      |  |           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  |         | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS   |  |  |  |  |  |       |  |      |  |           |  |
| No  |         | None   |  | N/A  |  | Mary Bender (sister)  |  | Pittsburgh, Pa.  |  |  |  |       |  |      |  |           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         | PART I DEATH WAS CAUSED BY:  |  | IMMEDIATE CAUSE (a)  |  | DUE TO, OR AS A CONSEQUENCE OF                                      |  | 15223  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |       |  |      |  |           |  |
|   |         |  |  | Alcoholism   |  |   |  |  |  |  |  |       |  |      |  |           |  |
|   |         |  |  | Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.  |  | (b)   |  | DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |       |  |      |  |           |  |
|   |         |  |  |  |  | (c)   |  |  |  |  |  |       |  |      |  |           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |         |  |  |  |  |   |  |  |  |  |  |       |  |      |  |           |  |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |       |  |      |  |           |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |  |  |  |  |       |  |      |  |           |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |       |  |      |  |           |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: |         | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | TITLE (SPECIFY)  |  | M.D. Assistant MEDICAL EXAMINER                                     |  | DATE SIGNED  |  | 11-11-84                                     |  |       |  |      |  |           |  |
| ACTUAL SIGNATURE  |         | Ann M. Dixon, M.D.   |  | ADDRESS  |  | 111 Penn St., Balto., Md. 21201                                     |  |  |  |  |  |       |  |      |  |           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |  |  |  |  |  |       |  |      |  |           |  |
| Cremation   |         | 11/13/84   |  | Green Mount Cemetery   |  | Baltimore Md.   |  |  |  |  |  |       |  |      |  |           |  |
| 24. FUNERAL DIRECTOR NAME   |         | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |  |       |  |      |  |           |  |
| E. Barnes   |         | Fleming Funeral Service - Benson, Md.  |  | NOV 14 1984  |  | Julia Davidson-Randall  |  |  |  |  |  |       |  |      |  |           |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25M

BP  
DHMH - 17  
(VR A15 ME (5))

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with #72 box after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of it.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |   |   |  |  |   |
|---|---|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Margaret Lucille Puckett</i>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>November 30, 1984</i>                          |  | 2b. HOUR<br>M<br><i></i>  |
| 3. SEX<br><i>Female</i>   | 4. RACE<br><i>White</i>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>Oct. 6, 1921</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>63</i> YRS.                                    |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Virginia</i>  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                    |   |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>4619 Pennington Avenue,</i> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Ret. Waitress</i> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Restaurant</i>  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |   |
| 13a. STATE<br><i>Maryland</i>   | 13b. COUNTY<br><i></i>  | 13c. CITY OR TOWN<br><i>Baltimore</i>   | 13e. STREET ADDRESS / ZIP CODE<br><i>4402 Fairhaven Ave., 21226</i>                      |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>George Washington Mitchell</i>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Turie Gibson</i>  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>NO</i>   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>225-18-6686</i>   | 17. INFORMANT<br><i>Mrs. Debbie Morgan</i><br>ADDRESS<br><i>Baltimore, Md. 21226</i><br><i>4619 Pennington Ave.,</i>  |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Respiratory arrest</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Malignant glioma of frontal lobe</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cerebral infarct</i><br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. |   |   |  |  | APPROPRIATE INTERVAL BETWEEN CAUSE AND DEATH<br><i>minutes</i>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><i>Cerebral infarct</i>   |   |   |  |  |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i></i> P.M. <i>19</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11-16-84</i> to <i>present</i> , that (I) (we) last saw the deceased alive on <i>11-16-84</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) signed and fast saw the body after death.   |   |   |  |  |   |
| 22b. SIGNATURE<br><i>S.R. GENTLE</i>  |   | DEGREE  |  | 22c. DATE SIGNED<br><i>Dec 84</i>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>S.R. GENTLE</i>   |   | 22e. ADDRESS<br><i>4700 Pennington Ave Bk 21226</i>   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>   | 23b. DATE<br><i>12/3/1984</i>   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Cedar Hill Cemetery</i>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore, A. A. Co., Md.</i>       |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>McGully Funeral Homes</i>  |   | ADDRESS<br><i>Baltimore, Md., 21225</i><br><i>237 E. Patapsco Ave.,</i>   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>DEC 6 1984</i>                                   |   |
|   |   |   |  | 25b. REGISTRAR'S SIGNATURE<br><i>W. Davidson-Hendall</i>                             |   |

BP



*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "RECEIVED" and "JAN 1941" are faintly visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |  |   |  |  |                                   | 7 4 3 0 1 8 6   |  |
|---|--|---|--|---|--|---|--|--|-----------------------------------|---|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.  |  |   |  |   |  |  |                                   |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Anna M. Pugh  |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 8, 1984   |  |  | 2b. HOUR<br>2:00 P.M.             |   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov. 15, 1909   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |                                   | IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |  |                                   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1245 Woodbourne Ave. (Residence) |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>1245 Woodbourne Ave. 21239  |                                   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Vicchio  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary DeTorie   |  |   |  |  |                                   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215-12-3755  |  | 17. INFORMANT<br>ADDRESS<br>David J. Pugh 1245 Woodbourne Ave. 21239  |  |   |  |  |                                   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>COLD</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____          |  |   |  |   |  |   |  |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>minutes</u><br><br><u>Yes.</u> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br><u>Diabetes Mellitus, C.H.F.</u>   |  |   |  |   |  |   |  |  |                                   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |                                   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |                                   |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>10/14</u> , 19 <u>84</u> , to <u>11/8</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>10/14</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |  |                                   |   |  |
| 22b. SIGNATURE<br><u>Dr. Lewis Olsen</u>  |  |   |  | DEGREE<br><u>MD</u><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><u>11/9/84</u>   |                                   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Lewis Olsen M.D.   |  |   |  | 22e. ADDRESS<br>1012 North Point Rd. Baltimore, Maryland  |  |   |  |  |                                   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>Nov 12 1984  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley Mem.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cockeysville Maryland                             |  |  |                                   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck, Inc. Baltimore, Maryland   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 13 1984  |  | 25b. REGISTRAR'S SIGNATURE<br><u>John Davidson-Randall</u>                                      |  |  |                                   |   |  |

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RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE  
WASHINGTON, D. C. 20535

| DATE             | TO             | FROM           | REMARKS         |
|------------------|----------------|----------------|-----------------|
| November 8, 1961 | Mr. Tolson     | Mr. DeLoach    | Re: [illegible] |
| November 7, 1961 | Mr. DeLoach    | Mr. Mohr       | Re: [illegible] |
| November 6, 1961 | Mr. Mohr       | Mr. Bishop     | Re: [illegible] |
| November 5, 1961 | Mr. Bishop     | Mr. Casper     | Re: [illegible] |
| November 4, 1961 | Mr. Casper     | Mr. Callahan   | Re: [illegible] |
| November 3, 1961 | Mr. Callahan   | Mr. Conrad     | Re: [illegible] |
| November 2, 1961 | Mr. Conrad     | Mr. Felt       | Re: [illegible] |
| November 1, 1961 | Mr. Felt       | Mr. Gale       | Re: [illegible] |
| October 31, 1961 | Mr. Gale       | Mr. Rosen      | Re: [illegible] |
| October 30, 1961 | Mr. Rosen      | Mr. Sullivan   | Re: [illegible] |
| October 29, 1961 | Mr. Sullivan   | Mr. Tavel      | Re: [illegible] |
| October 28, 1961 | Mr. Tavel      | Mr. Trotter    | Re: [illegible] |
| October 27, 1961 | Mr. Trotter    | Mr. Tele. Room | Re: [illegible] |
| October 26, 1961 | Mr. Tele. Room | Mr. Holmes     | Re: [illegible] |
| October 25, 1961 | Mr. Holmes     | Mr. Gandy      | Re: [illegible] |

1 - Mr. Tolson  
1 - Mr. DeLoach  
1 - Mr. Mohr  
1 - Mr. Bishop  
1 - Mr. Casper  
1 - Mr. Callahan  
1 - Mr. Conrad  
1 - Mr. Felt  
1 - Mr. Gale  
1 - Mr. Rosen  
1 - Mr. Sullivan  
1 - Mr. Tavel  
1 - Mr. Trotter  
1 - Mr. Tele. Room  
1 - Mr. Holmes  
1 - Mr. Gandy

ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED  
DATE 11-10-81 BY 60322  
UCBAW

1 - Mr. Tolson  
1 - Mr. DeLoach  
1 - Mr. Mohr  
1 - Mr. Bishop  
1 - Mr. Casper  
1 - Mr. Callahan  
1 - Mr. Conrad  
1 - Mr. Felt  
1 - Mr. Gale  
1 - Mr. Rosen  
1 - Mr. Sullivan  
1 - Mr. Tavel  
1 - Mr. Trotter  
1 - Mr. Tele. Room  
1 - Mr. Holmes  
1 - Mr. Gandy



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8430187

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |   |   |  |   |   |
|---|---|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Joseph Queen</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 29 84</b> |   | 2b. HOUR<br><b>556 AM</b>                                       |
| 3. SEX<br><b>M</b>  | 4. RACE<br><b>B</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 12 00</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>                            | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b> MD                                     |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Lutheran Hospital</b> |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |   |
| 13a. STATE<br><b>md</b>   |   | 13b. COUNTY<br><b>Belt</b>  | 13c. CITY OR TOWN<br><b>Balt</b>                       | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Thomas Queen</b>                     |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary F. Johnson</b>   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b> |   | 16b. SOCIAL SECURITY NO.<br><b>215 039255</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Mary Young 629 Radnor Ave.</b>                                   |   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**Cardiopulmonary Arrest**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

**Chronic myelogenous leukemia**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

**as a bowl**

|   |  |  |  |  |   |
|---|--|--|--|--|---|
| 19a. DATE OF OPERATION<br><b>11/29/84</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/29, 19 84</b> to <b>11/29, 19 84</b> , that (I) (we) last<br>saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |
| 22b. SIGNATURE<br><b>H. Okey MD</b>   |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>11/29/84</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Henry Okeyer</b>  |  | 22e. ADDRESS<br><b>Lutheran Hosp</b>                                   |  |  |   |

|  |                             |  |   |
|--|-----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>              | 23b. DATE<br><b>12/6/84</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Eastview mem. Pr.</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balt. MD</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March E/H 1101 E. North Ave.</b> |                             | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 4 1984</b>             |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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*[Faint, illegible handwriting on lined paper, possibly bleed-through from the reverse side.]*

*[Faint, illegible handwriting at the bottom of the page, possibly bleed-through from the reverse side.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonappers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal death certificate must be notified of.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |   |  |  |  |   |   |  |
|--|--|--|---|---|--|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Grace Randolph   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 30 84               |   | 2b. HOUR<br>8 35 P M   |  |  |   |   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Black   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Jan 14 1920   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>64 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><input checked="" type="checkbox"/> BALTIMORE CITY MD.   |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Domestic   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home                           |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.  |  |  | 13b. COUNTY<br>Balto.   |   | 13c. CITY OR TOWN<br>Turners St.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |   | 13e. STREET ADDRESS / ZIP CODE<br>645 N. Avondale Rd. 21222 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Norvel Dennis  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Grace Dennis |   |  |  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>219 18 7861   |   | 17. INFORMANT<br>ADDRESS<br>Herbert Randolph 137 Linden Ct.   |  |  |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic breast cancer</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>months</u>  |  |  |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Immed</u>        |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |   |  |  |  |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |   |  |
| 22a. I certify that (this hospital) attended the deceased from <u>OCT 16</u> , 19 <u>84</u> , to <u>NOV 30</u> , 19 <u>84</u> , that (we) last saw the deceased alive on <u>Nov 30</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |   |   |  |  |  |   |   |  |
| 22b. SIGNATURE<br><u>Susan M. Yeomans, M.D.</u>  |  |  |   | DEGREE<br><u>M.D.</u>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><u>11/30/84</u>                                 |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>SUSAN M. YEOMANS, M.D.</u>   |  |  |   | 22e. ADDRESS<br><u>UNION MEMORIAL HOSPITAL</u>  |  |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Burial</u>  |  | 23b. DATE<br><u>12/5/84</u>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Arbutus</u>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Baltimore, Md.</u>  |  |   |   |  |
| 24. FUNERAL DIRECTOR<br><u>James A. Morton &amp; Sons</u>  |  |  |   | 1701 Laurens St.  |  | 25a. DATE REC'D. BY REGISTRAR<br><u>DEC 3 1984</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Jana Davidson</u>                  |   |  |



UNITED STATES DEPARTMENT OF AGRICULTURE

WASHINGTON

20% COTTON FIBER

THEY CAN



Item 230 per ph. FOR 11/26/84

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

6 4 3 0 1 8 9

|   |  |  |  |   |   |  |   |   |  |
|---|--|--|--|---|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WILMONT</b> <b>C.</b> <b>RANDOLPH, JR.</b>   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>NOVEMBER 12, 1984</b> |   |   | 2b. HOUR P<br><b>8:48 M</b>  |   |   |  |
| 3 SEX<br><b>MALE</b>  |  | 4 RACE<br><b>BLACK</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>NOV. 4, 1984</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>8</b>                    |   | IF UNDER 1 YEAR<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>AT Home</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY                 |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br><b>MARYLAND</b> <b>BALTIMORE</b> <b>COCKEYSVILLE</b> |  |  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>1347 Western Run Rd. 21030</b> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>WILMONT C. RANDOLPH, JR.</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MAURSEN D LEE</b>   |   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |  |  |  | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT<br><b>FAMILY RECORDS</b>   |   |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**Cardiopulmonary Arrest**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**30 minutes**

DUE TO, OR AS A CONSEQUENCE OF

(b) **Overwhelming Sepsis****24 hours**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Necrotizing Enterocolitis with perforation****54 hours**

PART 2. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION

**11/10/84**

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

**Necrotizing Enterocolitis with Perforation**

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
**P.M. 19**

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION  
STREET CITY OR TOWN COUNTY STATE22a. I certify that (I) (this hospital) attended the deceased from **11/10**, 19 **84**, to **11/12**, 19 **84**, that (I) (we) lost  
saw the deceased alive on **11/12**, 19 **84**, and that in my (our) opinion death occurred on the date and hour and from the causes stated  
above. (If we did not view the body after death.)

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒**Paul Chambers Brewer M.D.****THE JOHNS HOPKINS HOSPITAL  
600 N. Wolfe St. Baltimore, Md 21205**23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)**BURIAL**

23b. DATE

**Nov. 16, 1984**

23c. NAME OF CEMETERY OR CREMATORY

**GOUGH V. MATH. CH.**23d. LOCATION  
CITY OR TOWN COUNTY STATE**COCKEYSVILLE BALTO. MARYLAND**24. FUNERAL DIRECTOR  
NAME ADDRESS**EVANS CHAPEL OF CHIMES****2325 YORK ROAD**

25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

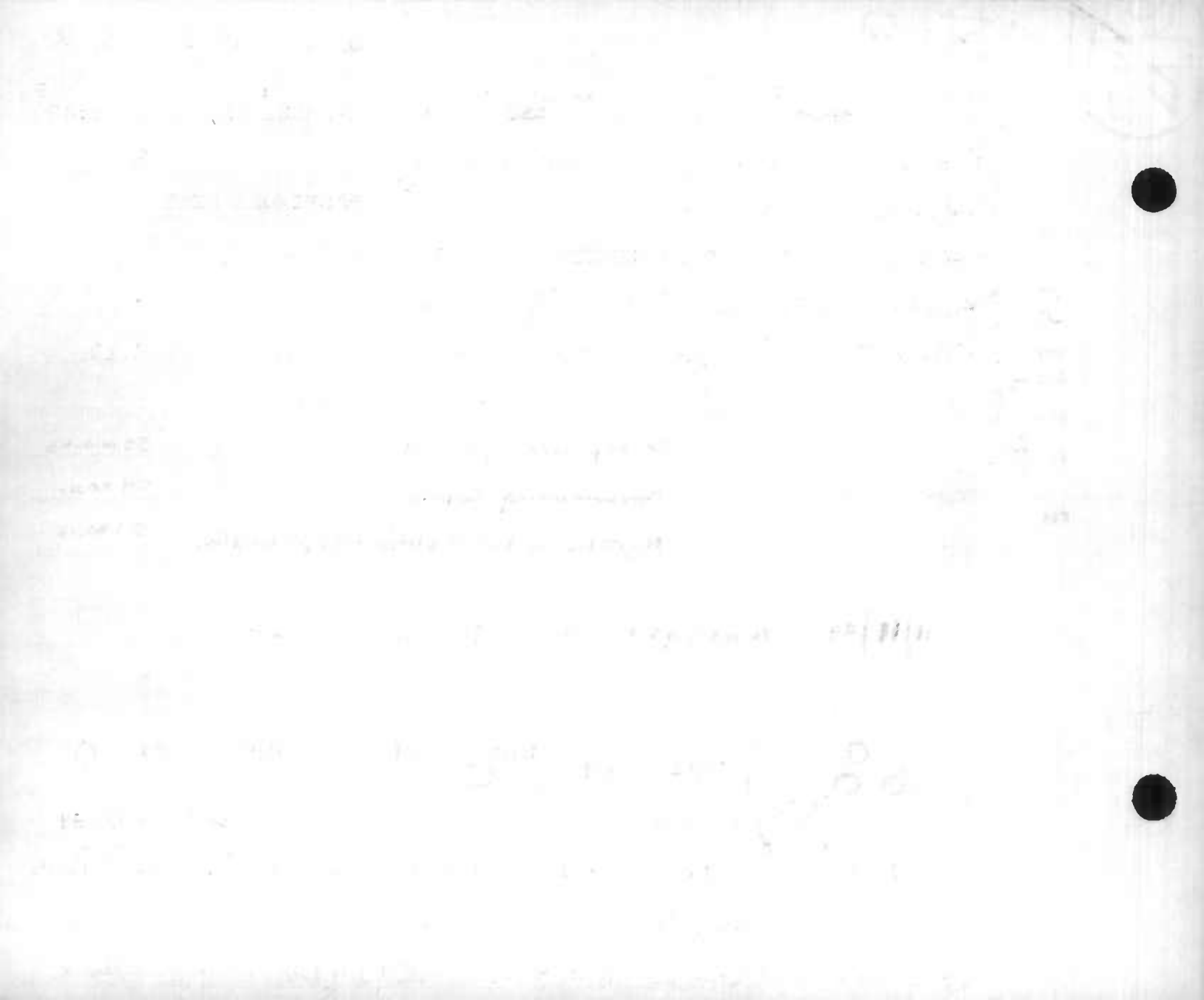
**NOV 16 1984****Julia Davidson-Randall**

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic, or other cause of death, the death certificate must be certified to one.



1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |   |  |  |  |  |  |   |  |
|---|--|--|---|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LEAVA - RATCHFORD</b>  |  |  | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>25</b> YEAR <b>84</b> |   |  | 2b. HOUR<br><b>1:31 AM</b>   |  |  |  |   |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>BLACK</b>  |   | 5. DATE OF BIRTH<br>MONTH <b>10</b> DAY <b>12</b> YEAR <b>09</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS <b>1</b> DAYS <b>10</b>                              |  | IF UNDER 24 HRS<br>HOURS <b>1</b> MIN. <b>31</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S. C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALT. CITY</b> <b>Flowers</b> MD.   |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIVERSITY MARYLAND HOSPITAL</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>UNEMPLOYED</b>  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>                |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |   |   |  |  |  |  |  |   |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>  |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>4029 PARK HEIGHTS ROAD 21215</b>          |  |   |  |
| 14. FATHER'S NAME<br><b>Andy</b> <b>Ferguson</b>  |  |  |   |   |  | 15. MOTHER'S MAIDEN NAME<br><b>Hester</b>  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |  |   | 16b. SOCIAL SECURITY NO.<br><b>212-20-5765</b>  |  | 17. INFORMANT<br><b>Mary Bell Chew</b> ADDRESS<br><b>5807 Rubin Ave.</b>   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b>  |  |  |   |   |  |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>20 min.</b>   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>MYOCARDIAL FAILURE</b>   |  |  |   |   |  |  |  |  |  | 1 1/2 hrs.  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |   |   |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |   |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION<br><b>8/27/84</b>  |  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>MASSIVE HEMOPTYSIS</b>   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/1/84</b> , 19 <b>84</b> , to <b>11/25</b> , 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>11/25</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>J. Flowers MD</b>  |  |  |   |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  | 22c. DATE SIGNED<br><b>11/25/84</b>                          |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JACK FLOWERS</b>  |  |  |   |   |  | 22e. ADDRESS<br><b>22 S. GREENE ST BALT, MD 21201</b>  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  |   | 23b. DATE<br><b>11/30/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn Cem.</b>   |  |  | 23d. LOCATION<br>CITY OR TOWN <b>Balto. Md.</b> COUNTY STATE |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H 1101 E. North Ave.</b>  |  |  |   |   |  | 25a. DATE REC'D BY REGISTRAR<br><b>NOV 28 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>                     |  |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                 |  |   |  |   |  |  |  | 30191<br>REG. NO.  |  |
|---|--|-----------------|--|---|--|---|--|--|--|--|--|
| 1- STATE REGISTRAR  |  |                 |  |   |  |   |  |  |  |  |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Johnnie Rauls JR.   |  |                 |  |   |  |   |  |  |  | 2a DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br>11/1/84                                |  |
| 3 SEX<br>MALE   |  | 4 RACE<br>Black |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>12 6 62  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>21 YRS                |  | IF UNDER 1 YR. MONTHS DAYS   |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>11/1/84                              |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  |                 |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.   |  |   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD                          |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore   |  |                 |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>555 E. 38th Street 21218 |  |   |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b KIND OF BUSINESS OR INDUSTRY   |  |
| 13a STATE<br>MARYLAND   |  |                 |  | 13b COUNTY  |  | 13c CITY OR TOWN<br>BALTIMORE                           |  | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e STREET ADDRESS<br>555 E. 38th STREET 21218                                     |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Johnnie Rauls Sr.  |  |                 |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>HATTIE BEST  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  |  |                 |  | 16b. SOCIAL SECURITY NO.  |  |   |  | 17. INFORMANT ADDRESS<br>CHART   |  |  |  |
| 18 CAUSE OF DEATH (Enter one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Transverse Myelitis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |                 |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                       |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1  |  |                 |  |   |  |   |  |  |  |  |  |
| 19a DATE OF OPERATION   |  |                 |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |  |  | 20 AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                 |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                 |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |   |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                 |  |   |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE<br>  |  |                 |  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER  |  |   |  | DATE SIGNED 11/2/84  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Gregory R. Kauffman, M.D.  |  |                 |  | ADDRESS<br>111 Penn St.   |  |   |  |  |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |                 |  | 23b DATE<br>11/5/84   |  | 23c NAME OF CEMETERY OR CREMATORY<br>ARBUTHNOT MEM. PK. |  |  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE BALTIMORE MARYLAND          |  |
| 24 FUNERAL DIRECTOR NAME<br>E.L. Phillips   |  |                 |  | ADDRESS<br>1721-27 N. MONROE  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 5 1984  |  |  |  |







STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

|   |  |  |   |   |                      |   |  |  |  |
|---|--|--|---|---|----------------------|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Frank E. Ray   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 9, 1984 |   | 2b. HOUR<br>8:30 A M |   |  |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Jan. 12, 1895   |                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br>89 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>781 Yale Avenue 21229 |   |   |                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Production Worker           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Plastic Mfg   |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br>Baltimore  |                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>781 Yale Avenue 21229  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Frank Ray   |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Dora Allen   |                      |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212 10 7246   |   | 17. INFORMANT<br>Ruth DiMartino   |                      | ADDRESS<br>781 Yale Avenue  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Widely disseminated carcinoma of the prostate.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Prostate.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ |  |  |   |   |                      |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>18 mos.  |  |
|   |  |  |   |   |                      |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                      |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                      |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from August 22, 1984, to November 9, 1984, that (I) (we) lost the deceased alive on Nov 7, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.   |  |  |   |   |                      |   |  |  |  |
| 22b. SIGNATURE<br>Dr. George Taler  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |                      |   |  | 22c. DATE SIGNED<br>Nov. 12, 1984.   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |   | 22e. ADDRESS<br>600 Light Street  |                      |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>11/12/1984  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Memorial  |                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland 21227                         |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Burgee-Henss Funeral Home 3631 Falls Rd. 21211  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 13 1984  |                      | 25b. REGISTRAR'S SIGNATURE<br>Julia L. ...  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 4 3 0 1 9 4

FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |   |   |  |
|--|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>JEAN E. RAY   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 27, 1984                      |   | 2b. HOUR<br>5:00 P.M.  |
| 3. SEX<br>Female   | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>June 27, 1918   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>66<br>YRS.                                 | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                    |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1631 Park Avenue |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home   |  |
| 13a. STATE<br>Maryland   |   | 13b. COUNTY<br>---  | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Leroy Brooks   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Julia E. Bohne               |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>218-07-1656  | 17. INFORMANT<br>ADDRESS<br>Raymond Ray 1666 Ocean Pines<br>Berlin, Md. 21811 |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>metastatic Breast Carcinoma</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____   |   |   |   |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/5</u> 19 <u>83</u> , to <u>10/27</u> 19 <u>84</u> , that (I) (we) lost <u>saw the deceased alive on 10/17</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) know the body after death.      |   |   |   |   |  |
| 22b. SIGNATURE<br><u>Davis Hahn</u>  |   | DEGREE<br><u>M.D.</u>   |   | 22c. DATE SIGNED<br><u>11/29/84</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Davis Hahn M.D.   |   | 22e. ADDRESS<br>5601 Loch Raven Blvd.<br>Baltimore, md. Suite 107   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   | 23b. DATE<br>11/30/84   | 23c. NAME OF CEMETERY OR CREMATORY<br>Woodlawn Cemetery   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Woodlawn Md.                    |   |  |
| 24. FUNERAL DIRECTOR<br>Leroy M. & Russell C. Witzke Funeral Homes P.A.<br>1630 Edmondson Avenue, Catonsville, Md. 21228   |   |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 30 1984                                  | 25b. REGISTRAR'S SIGNATURE<br><u>W. M. Hahn</u>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |  |  |   |  | REG. NO. 30195                               |  |
|--|--|---|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | I. DECEASED NAME (TYPE OR PRINT) <b>IRA</b>   |  |  |  | 2a. DATE OF DEATH MONTH <b>11</b> DAY <b>30</b> YEAR <b>84</b>                               |  | 2b. HOUR <b>M</b>   |  |  |  |
| 3. SEX <b>MALE</b>   |  | 4. RACE <b>NEGRO</b>  |  | 5. DATE OF BIRTH MONTH <b>6</b> DAY <b>6</b> YEAR <b>18</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS.   |  | IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>   |  | IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. MD.</b> MD.                                   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>BALTO.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>5303 Kenilworth Ave</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Labor</b>                   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b></b>   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>M.D.</b>   |  | 13b. COUNTY <b></b>   |  | 13c. CITY OR TOWN <b>BALTO.</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>5303 Kenilworth Ave</b> #21212   |  |  |  |
| 14. FATHER'S NAME FIRST <b>Henry</b> MIDDLE <b></b> LAST <b>Redmon</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Lilly</b> MIDDLE <b></b> LAST <b>Hylck</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>  |  | 16b. SOCIAL SECURITY NO. <b>215-14-7762</b>  |  | 17. INFORMANT ADDRESS <b>Mrs. Hill 4103 Hanwell Rd</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asthma</b>  |  |   |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <b></b>   |  |   |  |  |  |  |  |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>  |  |   |  |  |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>ASCUD</b>  |  |   |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR <b>A.M.</b> MONTH <b></b> DAY <b>19</b> P.M. <b></b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET <b></b> CITY OR TOWN <b></b> COUNTY <b></b> STATE <b></b>   |  |  |  |   |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>12/28/84</b> 19 <b>84</b> to <b>7/13/84</b> 19 <b>84</b> , that (I) (we) lost the deceased alive on <b>7/13</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE <b>Jesse T. Holmes</b>  |  | DEGREE <b>M.D.</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  |  |  | 22c. DATE SIGNED <b>12/3/84</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jesse T. Holmes M.D.</b>  |  | 22e. ADDRESS <b>2300 GARRISON Blvd, BALTO, Md</b>   |  |  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |  | 23b. DATE <b>12-6-84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>BALTO. Cem.</b>  |  | 23d. LOCATION CITY OR TOWN <b>BALTO.</b> COUNTY <b></b> STATE <b>M.D.</b>                    |  |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>Betts Funeral Home</b> ADDRESS <b>1129 N. Calhoun St</b>  |  | 25a. DATE REC'D. BY REGISTRAR <b>DEC 5 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>  |  |  |  |   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TQ FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |   |  |                                   |   |  |
|---|--|---|--|--|---|--|-----------------------------------|---|--|
| 1. FOR STATE REGISTRAR  |  | 8430196<br>REG. NO.   |  |  |   |  |                                   |   |  |
| I. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   |  | MIDDLE   |   | LAST   |                                   | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR   |  |
| FLORENCE Elizabeth REID   |  |   |  |  |   |  |                                   | 11/29/84 1:15 AM  |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH MONTH DAY YEAR                                     |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |   | IF UNDER 1 YEAR MONTHS DAYS  |                                   | IF UNDER 24 HRS. HOURS MIN.   |  |
| FEMALE  | BLACK  | 5 3 15  |  | 69 YRS.  |   |  |                                   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |  |                                   |   |  |
| BALTIMORE MD.   | U.S.A.   |   |  |  | Balto. CITY MD.   |  |                                   |   |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |
| BALTIMORE CITY  | LUTHERAN   |   |  |  | Barmaid   |  |                                   |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |  |   |  |                                   |   |  |
| 13a. STATE  | 13b. COUNTY  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS  |                                   |   |  |
| MD.   | BALTIMORE  |   |  |  |   | Baltimore, Md. 21216<br>1619 N. ROSEDALE ST.                           |                                   |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                          |  |  |   |  |                                   |   |  |
| John Frederick Thomas, Sr.  |  | Cardy Anna Mapp   |  |  |   |  |                                   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS  |   |  |                                   |   |  |
|   |  | 212-16-9725   |  | Mary A. Jackson Baltimore, Maryland 21217  |   |  |                                   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |   |  |  |   |  |                                   |   |  |
| PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) ADULT RESPIRATORY DISTRESS SYNDROME  |  |   |  |  |   |  |                                   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) HYPOTENSION / SHOCK  |  |   |  |  |   |  |                                   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |   |  |  |   |  |                                   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |  |  |   |  |                                   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)               |   |  |                                   |   |  |
|   |  | P.M. 19   |  |  |   |  |                                   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |  |                                   |   |  |
|   |  |   |  |  |   |  |                                   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/17 19 84 to 11/29 19 84, that (I) (we) last saw the deceased alive on 11/29 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |   |  |                                   |   |  |
| 22b. SIGNATURE  |  | DEGREE  |  |  |   | 22c. DATE SIGNED   |                                   |   |  |
| LUTHERAN L. C. CUTO   |  |   |  |  |   | 11/29/84   |                                   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |  |  |   |  |                                   |   |  |
| LUTHERAN L. C. CUTO   |  | LUTHERAN HOSPITAL   |  |  |   |  |                                   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION CITY OR TOWN COUNTY STATE                                |                                   |   |  |
| Burial  |  | 12/3/1984   |  | King Memorial Park   |   | Baltimore Co. Maryland   |                                   |   |  |
| 24. FUNERAL HOME OR OTHER PLACE OF BURIAL (NAME AND ADDRESS)  |  | 25a. DATE REC'D. BY REGISTRAR                                       |  |  |   | 25b. REGISTRAR'S SIGNATURE   |                                   |   |  |
| Nutter & Sons 2501 Gwynns Falls Parkway<br>Funeral Home Inc. Baltimore, Maryland 21216  |  | NOV 30 1984   |  |  |   | Jana Davidson-Hendall  |                                   |   |  |

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**Figure 2**

Mr. Jackson, Mr. Jones

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 4 3 0 1 9 7  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1- FOR STATE REGISTRAR  |  |   |  | REG. NO.   |  |   |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>WILMA REIMAN</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>11</b> YEAR <b>84</b> 2b. HOUR <b>11 P</b> M   |  |   |  |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>W</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>8</b> DAY <b>19</b> YEAR <b>33</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>51</b> YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NEW YORK</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SOUTH BALTIMORE General Hospital</b>        |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE <b>MARYLAND</b> 13c. COUNTY <b>BALTIMORE</b> 13d. CITY OR TOWN <b>Baltimore</b>  |  | 13e. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13f. STREET ADDRESS<br><b>8018 Gough Street</b>  |  |   |  |
| 14 FATHER'S NAME<br>FIRST <b>JOHN</b> MIDDLE <b>NEUMAN</b> LAST <b>NEUMAN</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>MAIRIE</b> MIDDLE <b>DECKER</b> LAST <b>DECKER</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b> 16b. SOCIAL SECURITY NO.<br><b>111-28-0325</b>                              |  |   |  |
| 17 INFORMANT<br><b>JOHN REIMAN</b>  |  | ADDRESS<br><b>8019 Gough St. Balt. Md.</b>  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Terminal abdominal Carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute pulmonary edema</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Intestinal obstruction</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Ovarian Carcinoma</b>  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/11/84</b> to <b>11/11/84</b> , that (I) (we) last saw the deceased alive on <b>11/11/84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Michael E. Klofies</b>   |  | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/11/84</b>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Michael E. Klofies</b>  |  | 22e. ADDRESS<br><b>30015 HANOVER ST. Baltimore, MD 21230</b>  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>11/15/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LAKE VIEW</b>   |  | 23d. LOCATION<br>CITY OR TOWN <b>BALTO.</b> COUNTY <b>MD.</b> STATE   |  |
| 24 FUNERAL DIRECTOR<br>NAME <b>J.G. CONNELLY</b> ADDRESS <b>300 MACE</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 14 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Davidson-Randall</b>   |  |   |  |

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CHIEF



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE **8 4 3 0 1 9 8**  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |   |   |  |
|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ALVIN C. RENSCHAW</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 02, 1984</b>                   |   | 2b. HOUR<br><b>9:30 P.M.</b>                                     |
| 3. SEX<br><b>M</b>  | 4. RACE<br><b>W</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8-22-1931</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>53</b> YRS.                                 |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY - MD.</b>                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>CHURCH HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CUTTER</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>TAILORING</b>            |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD.</b> |   |   | 13b. COUNTY<br><b>-</b>   |   | 13c. CITY OR TOWN<br><b>BALTO.</b>                               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ALVIN S. RENSCHAW</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ELSIE BRIEL</b>               |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                   |   | 16b. SOCIAL SECURITY NO.<br><b>218-28-0022</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Mr. Norman H. Renschaw - 1531 Chelworth Ave. 21220</b> |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**SEPSIS**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

**PNEUMONIA**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

**K RENAL FAILURE. HEPATIC FAILURE**

|   |  |   |  |  |   |
|---|--|---|--|--|---|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)        |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                      |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>OCTOBER 26, 1984</b> to <b>NOVEMBER 02, 1984</b> , that (I) (we) lost<br>saw the deceased alive on <b>NOVEMBER 02, 1984</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) did (did not) view the body after death. |  |   |  |  |   |
| 22b. SIGNATURE<br><b>Nazemi M.D.</b>  |  | DEGREE  |  | 22c. DATE SIGNED<br><b>11/2/84</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ATOALLAH F. NAZEMI M.D.</b>   |  | 22e. ADDRESS<br><b>CHURCH HOSPITAL CORPORATION<br/>100 NORTH BROADWAY BALTO., MD. 21231</b> |  |  |   |

MEDICAL CERTIFICATION

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|  |                             |   |  |
|--|-----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>          | 23b. DATE<br><b>11-6-84</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CEDAR HILL Cem.</b>  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO., MD.</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Funeral Home - 7527 Harford Rd.</b> |                             | 25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>NOV 7 1984</b> <i>Jana Davidson-Hendell</i> |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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BALTIMORE CITY

CHURCH HOSPITAL  
CITY

101 E. LINCOLN AVE

101 E. LINCOLN AVE

RENSHAW

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |   |  |  |   |   |
|---|--|---|--|---|---|--|--|---|---|
| 1. FOR STATE REGISTRAR  |  |   |  |   | 8 4 3 0 1 9 9                                 |  |  |   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  |   | 2a. DATE OF DEATH                             |  |  |   |   |
| Hannah Reynolds   |  |   |  |   | November 8, 1984                              |  |  |   |   |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |   | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 2b. HOUR  |   |
| Female  |  | Black   |  | 11 MONTH 25 DAY 85 YEAR   |   | 98 YRS.  |  | M   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |   |
| N.C.  |  | USA   |  |   |   | Baltimore City MD.   |  |   |   |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |   |  |  |   |   |
| Baltimore   |  | 1611 Darley Avenue  |  |   |   |  |  |   |   |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |   |  |  |   |   |
|   |  |   |  |   |   |  |  |   |   |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |   | 13d. STREET ADDRESS  |  |   |   |
| MD  |  |   |  | Baltimore   |   | 1611 Darley Avenue 21213   |  |   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST |  |  |   |   |
| Israel Williams   |  |   |  |   | Jane Williams                                 |  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |  |   |  |   | 16b. SOCIAL SECURITY NO.                      |  | 17. INFORMANT ADDRESS                      |   |   |
| No  |  |   |  |   | 212-74-4862                                   |  | Catherine Richardson 1611 Darley Ave.      |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardio pulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____   |  |   |  |   |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |  |   |   |  |  |   |   |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9-24-</u> 19 <u>84</u> , to <u>9-24-</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>9-24-</u> 19 <u>84</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   | 22b. SIGNATURE<br><u>Kathleen Brunt S.</u>                             |   |   | 22c. DATE SIGNED<br><u>11-9-84</u>   |  |   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   | 22e. ADDRESS   |   |   |  |  |   |   |
| Kathleen Brunt S.   |  |   | 1000 E. Eager Balto. MD.   |   |   |  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>SPECIFIC   |  |   | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY            |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |   |   |
| Burial  |  |   | 11/13/84   |   | Union Hill Cem.                               |  | Nashville N.C.                             |   |   |
| 24. FUNERAL DIRECTOR<br>NAME  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR                 |  | 25b. REGISTRAR'S SIGNATURE                 |   |   |
| Wm. C. March F/H 1101 E. North Ave.   |  |   |  |   | NOV 9 1984                                    |  | <u>[Signature]</u>                         |   |   |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |   |  |  |  |  |   |   | REG. NO. 8 4 3 0 2 0 0                               |  |   |  |
|---|--|---|---|--|--|--|--|---|---|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |   |  | 20. DATE OF DEATH MONTH DAY YEAR 11 25 84  |  |  |   |   |  |  | 2b. HOUR 12 30 P. M.  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VIRGIL REYNOLDS  |  |   |   |  | 20. DATE OF DEATH MONTH DAY YEAR 11 25 84  |  |  |   |   | 2b. HOUR 12 30 P. M.                                 |  |   |  |
| 3. SEX male   |  | 4. RACE Black   |   | 5. DATE OF BIRTH MONTH DAY YEAR 10 - 3 - 1894  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS                         |   | IF UNDER 24 HRS. HOURS MIN.                          |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Car.  |  | 7b. CITIZEN OF WHAT COUNTRY? USA  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.                        |  |   |   |  |  |   |  |
| 10. CITY OR TOWN OF DEATH Balto.  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Provident Hospital |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |  |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |   |   |  |  | 13e. STREET ADDRESS / ZIP CODE 1105 Woodington Rd. Apt. 5 21229 |  |
| 13a. STATE Md.  |  | 13b. COUNTY   |   | 13c. CITY OR TOWN Balto.   |  | 13e. STREET ADDRESS / ZIP CODE 1105 Woodington Rd. Apt. 5 21229                |  |   |   |  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Virgil Reynolds   |  |   |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie  |  |  |   |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes   |  |   |   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS Rosa A. Reynolds 1105 Woodington Rd. Apt. 5      |   |   |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiac arrest   |  |   |   |  |  |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Septic   |  |   |   |  |  |  |  |   |   | 1 hour   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) Unknown to physician   |  |   |   |  |  |  |  |   |   | week   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: G.I. Bleed   |  |   |   |  |  |  |  |   |   |  |  |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |   |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |   |   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-4-19-84 to 11-25-19-84, that (I) (we) lost saw the deceased alive on 11-25-19-84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |   |  |  |  |  |   |   |  |  |   |  |
| 22b. SIGNATURE [Signature]  |  |   |   |  | DEGREE   |  |  |   | 22c. DATE SIGNED  |  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Larry S. Penney M.D.  |  |   |   |  | 22e. ADDRESS 107 E. Lombard St. Balto., Md.  |  |  |   |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |  |   | 23b. DATE 11/30/84  |  | 23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park                                     |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md. |   |  |  |   |  |
| 24. FUNERAL DIRECTOR NAME Leroy O. Dyett 4600 Liberty Hgts. Ave   |  |   |   |  | 25. DATE REC'D. BY REGISTRAR NOV 28 1984   |  | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall                      |   |   |  |  |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as (b) or (c), show any injury or other traumatic event, the medical examiner must be notified at once.

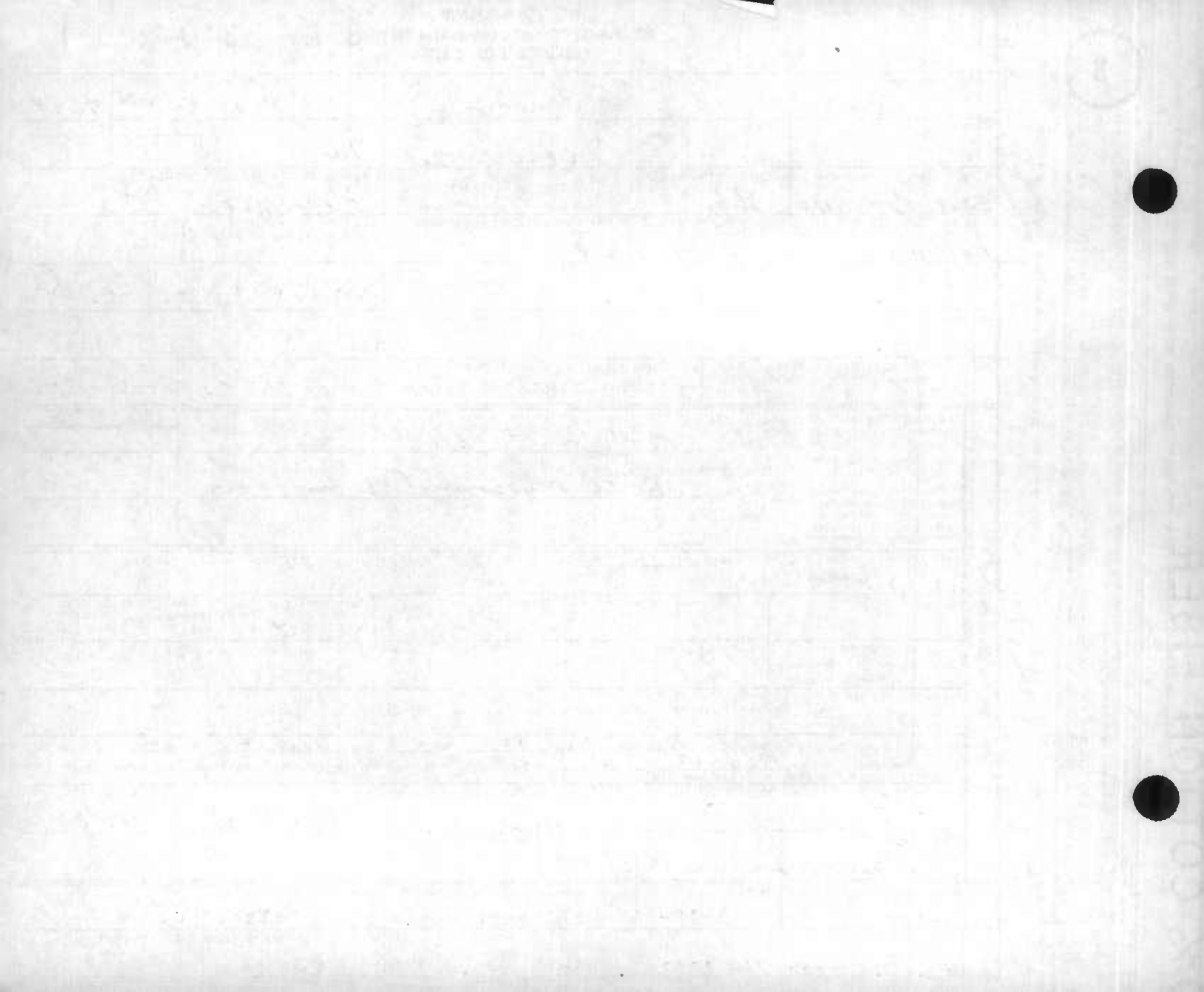
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(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |
|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Ruth J Rhodes</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>Nov 12 1984</b>   |  | 2b. HOUR<br><b>7:54 P.M.</b>   |
| 3 SEX<br><b>F</b>  | 4 RACE<br><b>N</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>06-05-12</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>South Carolina</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Lutheran</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY  | 13c. CITY OR TOWN<br><b>Balto.</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unk.</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unk.</b>   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>251-09-7485</b>   |  | 17. INFORMANT<br><b>D Betty Rhodes</b>   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Malignant arrhythmias</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Acute Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Hypertension</b>  |  |  |  |  |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 12</b> 19 <b>84</b> , to <b>Nov 12</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>Nov 12</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |
| 22b. SIGNATURE<br><b>Joseph LaRue Richter</b>  |  | DEGREE<br><b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/12/84</b>  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11-19-84</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt Auburn Cem.</b>                          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 14 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>G. J. ...</i>   |
| ADDRESS<br><b>1101 E. North Ave.</b>   |  | CITY OR TOWN<br><b>Balto. Md.</b>  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1- STATE  
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |   |  |  |
|--|--|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><u>Napolean</u> <u>Richardson</u>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><u>11</u> <u>10</u> <u>84</u> |   | 2b. HOUR<br><u>12</u> <u>45</u> <u>AM</u> |  |  |
| 3 SEX<br><u>male</u>   |  | 4 RACE<br><u>Black</u>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><u>10</u> <u>28</u> <u>19</u>   |   | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><u>65</u> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Rocky Mt. N. Cal</u>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Baltimore</u> <u>City</u> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><u>Baltimore</u>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><u>Provident Hospital</u>   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><u>Md</u>  |  | 13b. COUNTY<br><u>Balto</u>  |  | 13c. CITY OR TOWN<br><u>Balto</u>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>William</u> <u>Richardson</u>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>Peggy</u> <u>Lee</u> <u>Jarrell</u>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>NO</u>   |   | 16b. SOCIAL SECURITY NO.<br><u>215-22-7475</u>   |  |
| 17. INFORMATION<br>ADDRESS<br><u>Daisey Richardson 1707 W. North Ave.</u>  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio Pulmonary Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Oats Cell Carcinoma - Metastasis to Bone + Brain</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |   |  |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>   |  |  |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><u>P.M.</u> <u>19</u>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/9</u> , 19 <u>84</u> , to <u>11/10</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>11/10</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |  |  |
| 22b. SIGNATURE<br><u>Eleanor Y. Hixon, MD</u>  |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |   | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Eleanor Y. Hixon MD</u>  |  | 22e. ADDRESS<br><u>3100 TOWANDA AVE</u>  |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE OR PRINT)<br><u>Burial</u>  |  | 23b. DATE<br><u>11-14-84</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Arbutus Mem. Pk.</u>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Balta</u> <u>Ind</u>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Geroy A. Syte 4600 Liberty Hgts.</u>  |  | 25. DATE REC'D. BY REGISTRAR<br><u>NOV 13 1984</u>   |  | 26. REGISTRAR'S SIGNATURE<br><u>John Davidson-Randall</u>   |   |  |  |

BP

11 10 24

Black ...  
W 28 ...  
Black + 16 ...

Mr ...  
William ...  
210 25 ...

...

...

...

...

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 3 0 2 0 3

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>SYNETTA Richardson</i>                       |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>11 23 84</i> |   |  | 2b. HOUR<br><i>9:10 PM</i>  |  |
| 3. SEX<br><i>Female</i>   |  | 4. RACE<br><i>Black</i>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>2 16 29</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><i>55</i>                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>S. C.</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore Md</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Provident Hospital</i> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  |
| 13a. STATE<br><i>Md.</i>  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><i>Balto.</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Barry Steward</i>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Carrie Sullivan</i>  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES<br><i>No</i> |  | 16b. SOCIAL SECURITY NO.<br><i>263-12-9691</i>   |  | 17. INFORMANT ADDRESS<br><i>Kenneth Richardson 4013 Bateman Ave.</i>  |  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*asystole*

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.(b) *cardiac failure*

DUE TO, OR AS A CONSEQUENCE OF

(c) *ischemic heart disease*APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHPART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: *a*

MEDICAL CERTIFICATION

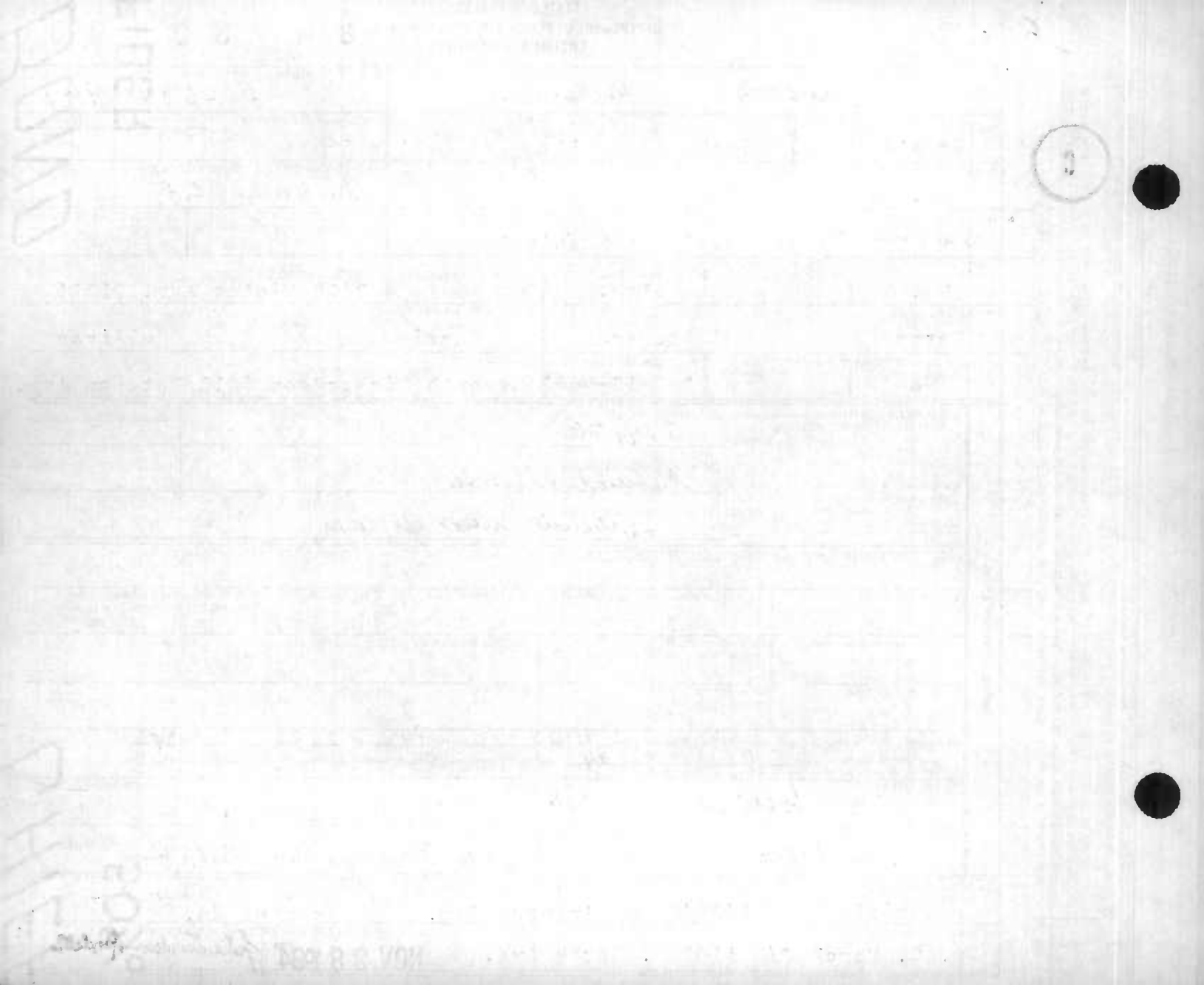
|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11/22</i> , 19 <i>84</i> , to <i>11/23</i> , 19 <i>84</i> , that (I) (we) lost<br>saw the deceased alive on <i>11/23</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><i>Raul Lopez</i>   |  | DEGREE<br><i>MD</i>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Raul Lopez</i>  |  |  |  | 22e. ADDRESS<br><i>3100 Fownde Ave. Baltimore</i>  |  |   |  |

|  |  |                              |  |  |  |  |  |
|--|--|------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>                      |  | 23b. DATE<br><i>11/29/84</i> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Arbutus Cem.</i>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Arbutus Md.</i> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Wm. C. March F/H 1101 E. North Ave.</i> |  |                              |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><i>NOV 28 1984 Julia Davidson-Rodell</i> |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 3 0 2 0 4

|   |  |  |  |
|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>CROCKETT G. RIGGINS</b>  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>NOVEMBER 4, 1984</b><br>2b. HOUR<br><b>10:14 am</b>   |  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>11 23 22</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>TENN.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>61</b><br>IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.<br>YRS.                         |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 13a. STATE<br><b>MD.</b>  | 13b. COUNTY<br><b>BALTO.</b>   | 13c. STREET ADDRESS / ZIP CODE<br><b>718 PARK AVE. 21201</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Lorenzo Dow</b>   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Josephine Burden</b>  | 12a. USUAL OCCUPATION (OF WORK PRIOR TO DEATH)<br><b>Unemployed</b>  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   | 16b. SOCIAL SECURITY NO.<br><b>417-24-4567</b>   | 17. INFORMANT ADDRESS<br><b>Mrs. Dorothy Riggins (same as above)</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Atherosclerotic Coronary Vascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>unknown</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a<br><b>Gastrointestinal Bleed</b>   |  |  |  |
| 19a. DATE OF OPERATION<br><b>November 3, 1984</b>   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Gastrointestinal Bleed</b>  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>November 3, 1984</b> , to <b>November 4, 1984</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>November 4, 1984</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> (not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br><b>Gail Glotfelty M.D.</b>  | DEGREE<br><b>M.D.</b>  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br><b>11-4-84</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GAIL GLOTFELTY M.D.</b>   |  | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>   |  |
| 23a. BURIAL (CREMATION REMOVAL) (SPECIFY)<br><b>Cremated</b>  | 23b. DATE<br><b>11/6/84</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenwood Cem.</b>  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>   |
| 24. FUNERAL DIRECTOR<br><b>L. Carroll</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 13 1984</b>  | 25b. REGISTRAR'S SIGNATURE<br><b>Lia Davidson-Randall</b>  |

BP 13





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner has been notified and an autopsy is required.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |  |  |  |   |   |  |
|--|--|---|--|--|--|--|---|---|--|
| 1 - FOR STATE REGISTRAR  |  |   |  |  | 7 4 3 0 2 0 5<br>REG. NO.  |  |   |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <i>Florence M. Rigney</i>   |  |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR HOUR <i>11 28 84 3 AM</i>                                   |  |   |   |  |
| 3. SEX <i>Female</i>   |  | 4. RACE <i>CAUCASIAN</i>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <i>11 28 1901</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <i>94</i> 95 YRS                               |   | 7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>England</i>   |  | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.                 |   |   |  |
| 10. CITY OR TOWN OF DEATH <i>Baltimore</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Edgewood Nursing Home</i> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i> |   | 12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i> |  |
| 13a. STATE <i>Maryland</i> 13b. COUNTY <i>Anne Arundel</i> 13c. CITY OR TOWN <i>Glen Burnie</i>  |  |   |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Edwin Thomas Habgood</i>  |  |   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Ann Newman</i>                            |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>  |  | 16b. SOCIAL SECURITY NO. <i>214-20-8900D</i>  |  | 17. INFORMANT ADDRESS <i>Balto., Md. 21234</i>   |  |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>arteriosclerotic Cardiovascular Disease</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ |  |   |  |  |  |  |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>8/11 19 84</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>8/11</i> to <i>11/28</i> 19 <i>84</i> that (I) (we) last saw the deceased alive on <i>11/27</i> 19 <i>84</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did not) view the body after death.  |  |   |  |  |  |  |   |   |  |
| 22b. SIGNATURE <i>Thomas L. Worsley M.D.</i> DEGREE <i>M.D.</i>  |  |   |  | 22c. DATE SIGNED <i>11/29/84</i>   |  |  | 22d. ADDRESS <i>6505 York Road, Baltimore, Md. 21212</i>  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>  |  | 23b. DATE <i>12-1-84</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY <i>Woodlawn</i>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Maryland</i>              |   |   |  |
| 24. FUNERAL DIRECTOR NAME <i>Ruck Towson Funeral Home, Inc.</i> ADDRESS <i>1050 York Rd. Towson, Md. 21204</i>   |  |   |  | 25. DATE REC'D. BY REGISTRAR <i>NOV 30 1984</i>  |  | 25b. REGISTRAR'S SIGNATURE <i>Thomas L. Worsley</i>                            |   |   |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 30206

1- FOR  
STATE  
REGISTRAR

|  |  |             |                 |   |  |  |  |   |                |  |  |   |  |   |                        |  |  |                       |  |
|--|--|-------------|-----------------|---|--|--|--|---|----------------|--|--|---|--|---|------------------------|--|--|-----------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |             | FIRST<br>Robert |   |  | MIDDLE<br>E. L.  |  |   | LAST<br>Ringle |  |  | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED XX 11-16 1984     |  |   | 2b. HOUR<br>M          |  |  |                       |  |
| 3 SEX<br>M   |  | 4 RACE<br>W |                 | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3/2/31  |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)<br>23 YRS.                  |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |                | IF UNDER 24 HRS.   |  | 7c. DATE<br>PRONOUNCED<br>DEAD 11-16 1984                   |  |   | 7d. HOUR<br>11:10 a. M |  |  |                       |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br>Baltimore  |  |             |                 | 7b. CITIZEN OF WHAT COUNTRY?<br>—   |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD. |  |   |                        |  |  |                       |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |             |                 | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1015 Cathedral St., Apt. 2C |  |  |  |   |                | 12a. USUAL OCCUPATION (TYPE OF WORK<br>OR MOST OF WORKING LIFE)<br>Electrician |  |   |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY<br>— |                        |  |  |                       |  |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>No. ST. Md.   |  |             |                 | 13b. COUNTY<br>—  |  | 13c. CITY OR TOWN<br>Baltimore                                 |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                | 13e. STREET ADDRESS<br>1015 Cathedral St. 31201                                |  |   |  |   |                        |  |  |                       |  |
| 14. FATHER'S NAME<br>Charles K. Ringle   |  |             |                 |   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>Florence Koch   |                |  |  |   |  |   |                        |  |  |                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(TYPE AND OR UNKNOWN)<br>Yes   |  |             |                 | 16b. SOCIAL SECURITY NO.<br>Korean Army 314 36 3550   |  |  |  | 17. INFORMANT<br>Address<br>Hennis Peltier 31330 124 1st St. Balto.   |                |  |  |   |  |   |                        |  |  |                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:   |  |             |                 |   |  |  |  |   |                |  |  |   |  |   |                        | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH    |  |                       |  |
| IMMEDIATE CAUSE (a) Fatty Liver  |  |             |                 |   |  |  |  |   |                |  |  |   |  |   |                        |  |  |                       |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |             |                 |   |  |  |  |   |                |  |  |   |  |   |                        |  |  |                       |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |  |             |                 |   |  |  |  |   |                |  |  |   |  |   |                        |  |  |                       |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF   |  |             |                 |   |  |  |  |   |                |  |  |   |  |   |                        |  |  |                       |  |
| (c)  |  |             |                 |   |  |  |  |   |                |  |  |   |  |   |                        |  |  |                       |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |             |                 |   |  |  |  |   |                |  |  |   |  |   |                        |  |  |                       |  |
| 19a. DATE OF OPERATION   |  |             |                 |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?              |  |   |                |  |  |   |  |   |                        | 20. AUTOPSY?<br>YES XX NO <input type="checkbox"/> |  |                       |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |             |                 |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19     |  |   |                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |   |  |   |                        |  |  |                       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |             |                 |   |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.) |  |   |                | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |   |                        |  |  |                       |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |             |                 |   |  |  |  |   |                |  |  |   |  |   |                        |  |  |                       |  |
| ACTUAL SIGNATURE<br>Thomas D. Smith  |  |             |                 |   |  | TITLE (SPECIFY)<br>M.D. Deputy Chief                           |  |   |                |  |  | DATE SIGNED<br>11-16-84                                     |  |   |                        |  |  |                       |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |  |             |                 |   |  | ADDRESS<br>111 Penn St., Balto., Md. 21201                     |  |   |                |  |  |   |  |   |                        |  |  |                       |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE)  |  |             |                 |   |  | 23b. DATE<br>11/30/84  |  |   |                |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Catholics             |  |   |                        |  |  | 23d. LOCATION<br>City |  |
| 24. SIGNATURE OF REGISTRAR<br>Charles P. Henderson   |  |             |                 |   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 16 1984                   |  |   |                |  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles P. Henderson          |  |   |                        |  |  |                       |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

10/13/10

Mr. Charles W. Hughes  
1015 Chestnut St.  
Philadelphia, Pa.

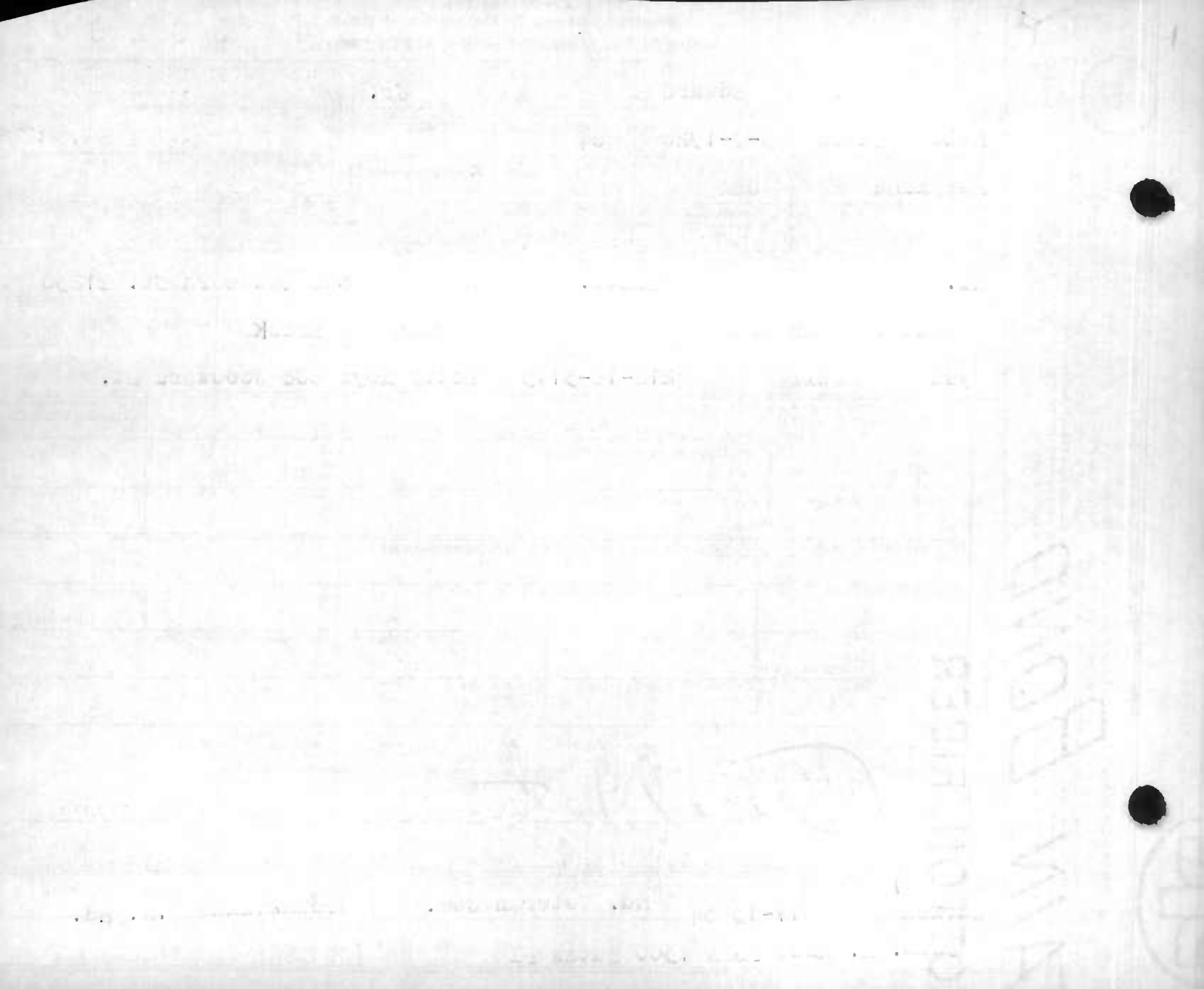
Wm. B. Hughes  
1015 Chestnut St.  
Philadelphia, Pa.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |         |                  |   |   |                  |  |      |  |                                      | REG. NO. 30207                               |    |
|--|---------|------------------|---|---|------------------|--|------|--|--------------------------------------|--|----|
| 1- STATE REGISTRAR   |         |                  |   |   |                  |  |      |  |                                      |  |    |
| 1. DECEASED NAME<br>(1 TYPE OR PRINT)  |         |                  | FIRST   |   | MIDDLE           |  | LAST |  | 2a. DATE KNOWN OF DEATH MATED        |  | XX |
| Walter Edward Ringgold Jr.   |         |                  |   |   |                  |  |      |  | 11 8 19 84                           |  | M  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS)   | IF UNDER 1 YR.  | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD   |      | MONTH DAY YEAR   |                                      | 2d. HOUR                                     |    |
| Male   | Black   | 3-9-1920         | 64 YRS.   |   |                  | 11 8 19 84   |      |  |                                      | 1:22A  |    |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         |                  | 7b. CITIZEN OF WHAT COUNTRY?  |   |                  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |      |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |    |
| Maryland   |         |                  | USA   |   |                  |  |      |  | Baltimore City, MD                   |  |    |
| 10. CITY OR TOWN OF DEATH  |         |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |      |  | 12b. KIND OF BUSINESS OR INDUSTRY    |  |    |
| Baltimore  |         |                  | University Hospital   |   |                  |  |      |  |                                      |  |    |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |         |                  |   |   |                  |  |      |  |                                      |  |    |
| 13a. STATE   |         | 13b. COUNTY      |   | 13c. CITY OR TOWN   |                  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>  |      | 13e. STREET ADDRESS  |                                      |  |    |
| Md.  |         |                  |   | Balto.  |                  |  |      | 808 Woodward St. 21230   |                                      |  |    |
| 14. FATHER'S NAME  |         |                  |   |   |                  | 15. MOTHER'S MAIDEN NAME   |      |  |                                      |  |    |
| Walter Ringgold  |         |                  |   |   |                  | Emma Brooks  |      |  |                                      |  |    |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |         |                  |   | 16b. SOCIAL SECURITY NO.                                    |                  | 17. INFORMANT ADDRESS  |      |  |                                      |  |    |
| yes  |         |                  |   | WWII  |                  | 212-16-3113 Betty Keys 808 Woodward St.  |      |  |                                      |  |    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |         |                  |   |   |                  |  |      |  |                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |    |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |         |                  |   |   |                  |  |      |  |                                      |  |    |
| 19a. DATE OF OPERATION   |         |                  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |                  |  |      | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                      |  |    |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         |                  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19        |                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |      |  |                                      |  |    |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |         |                  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |                  | 21f. LOCATION STREET   |      | CITY OR TOWN   |                                      | COUNTY STATE                                 |    |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |                  |   |   |                  |  |      |  |                                      |  |    |
| ACTUAL SIGNATURE   |         |                  |   | TITLE (SPECIFY)   |                  |  |      | DATE SIGNED  |                                      |  |    |
| Thomas D. Smith, M.D.  |         |                  |   | Deputy Chief  |                  |  |      | 11/8/84  |                                      |  |    |
| EXAMINER'S NAME (TYPE OR PRINT)  |         |                  |   | ADDRESS   |                  |  |      |  |                                      |  |    |
| Burial   |         |                  |   | 11-13-84  |                  |  |      | Md. Veteran Cem.   |                                      |  |    |
| 23b. DATE  |         |                  |   | 23c. NAME OF CEMETERY OR CREMATORY                          |                  |  |      | 23d. LOCATION CITY OR TOWN COUNTY STATE  |                                      |  |    |
|  |         |                  |   | Crownsville A.A. Md.  |                  |  |      |  |                                      |  |    |
| 24. FUNERAL DIRECTOR NAME  |         |                  |   |   |                  | 25a. DATE REC'D. BY REGISTRAR  |      | 25b. REGISTRAR'S SIGNATURE   |                                      |  |    |
| Chas. A. Rice FSPA 1300 Eutaw Pl   |         |                  |   |   |                  | NOV 13 1984  |      | Julia Davidson-Randall   |                                      |  |    |

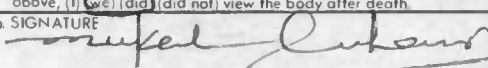





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 4 and 5 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked at item 18, a medical examiner's report is required.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |   |   |                               |  |  |
|---|--|---|--|---|---|---|-------------------------------|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   | REG. NO. 8 4 3 0 2 0 8  |   |                               |  |  |
| I. DECEASED NAME<br>(TYPE OR PRINT) <b>FLORENCE H. RITTER</b>   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 6, 1984</b>              |   |                               | 2b. HOUR<br><b>8:40 A.M.</b>   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 22 1908</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.   |                               | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |                               |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Hospital Corporation</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OR WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>                                |                               | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  | 13b. CITY OR TOWN<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |                               | 13e. STREET ADDRESS / ZIP CODE<br><b>7616 Hackett Avenue 21224</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Walter S. Bellis, Sr.</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Gertrude D. Harkins</b> |   |                               |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>213-20-5616</b>  |  | 17. INFORMANT<br><b>Calvin K. Ritter</b>  |   |   | ADDRESS<br><b>Same as 13e</b> |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>ACUTE MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |   |   |   |                               |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |   |   |                               |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                |                               | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |   |                               |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |                               |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>October 27, 84</b> , to <b>November 6, 1984</b> , that (I) (we) last saw the deceased alive on <b>November 6, 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                 |  |   |  |   |   |   |                               |  |  |
| 22b. SIGNATURE<br>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   | 22c. DATE SIGNED  |                               |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Mukesh Luhar, M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>CHURCH HOSPITAL<br/>100 N. BROADWAY, BALTO., MD 21231</b>  |   |   |                               |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>11/9/1984</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>   |                               |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Duda-Ruck, Inc.<br/>7922 Wise Avenue Dundalk, MD. 21222</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 8 1984</b>  |   | 25b. REGISTRAR'S SIGNATURE<br> |                               |  |  |

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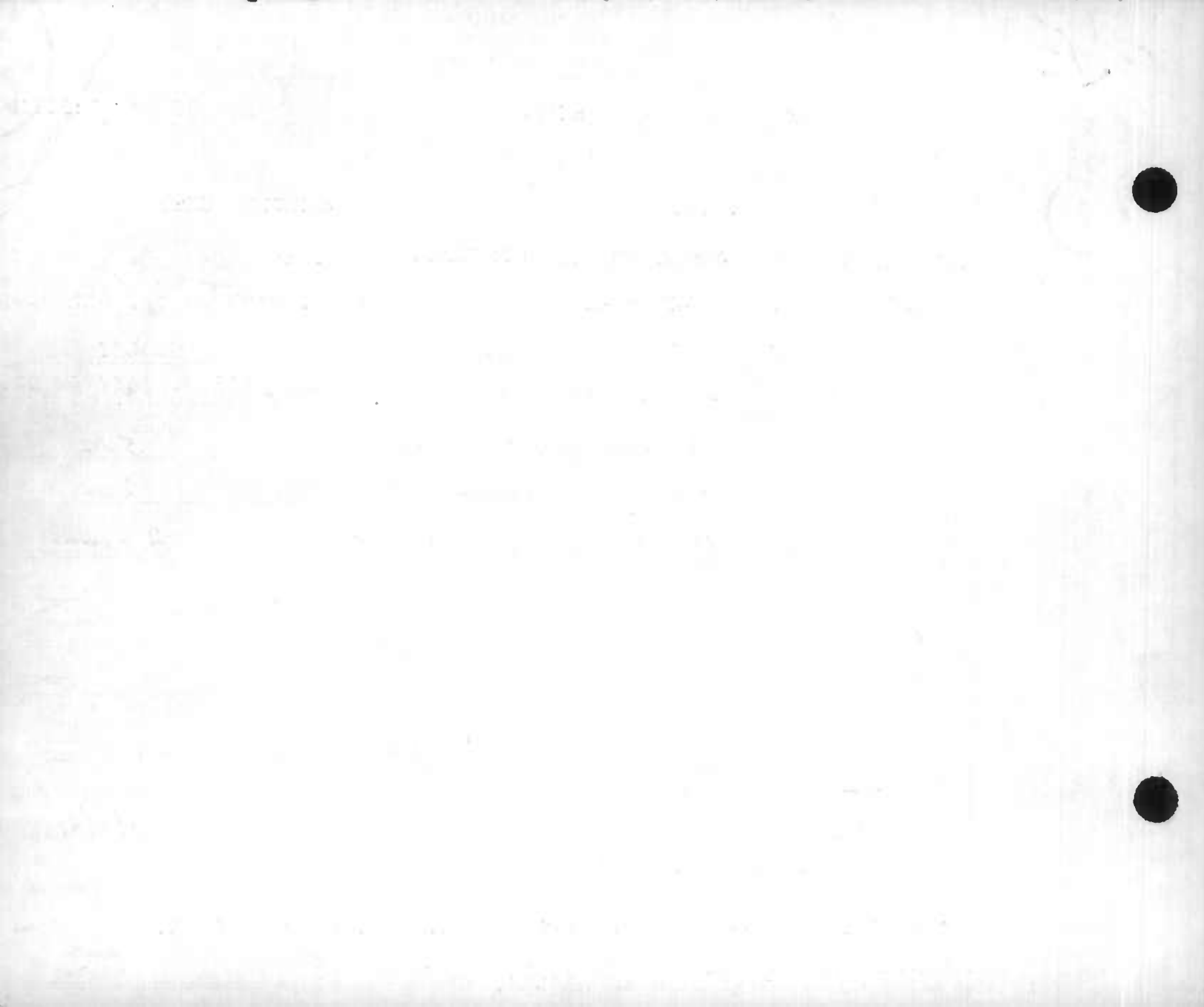


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is marked, any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |   |  |   | 8 4 3 0 2 0 9 |  |
|---|--|--|--|---|--|---|---|--|---|---------------|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.   |  |   |  |   |   |  |   |               |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ALBERT H RIVEST</b>  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 06 84</b>                 |   |   | 2b. HOUR<br><b>7:15 PM</b>   |   |               |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>APRIL 14, 1921</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |   |               |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MASSACHUSETTS</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                         |   |  |   |               |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>COMM. ENGINEER</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. GOV'T</b>   |   |               |  |
| 13a. STATE<br><b>MARYLAND</b>   |  |  |  |   | 13b. CITY OR TOWN<br><b>ANNAPOLIS</b>                                  |   | 13c. STREET ADDRESS / ZIP CODE<br><b>116 W. BAYVIEW DR. HILLSMERE</b> |  |   |               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HERVE DELPHUS RIVEST</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>EVALINA GOULET</b> |   |   |  |   |               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>1938-1945</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>015-03-6050</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>MARGARET J. RIVEST 116 W. BAYVIEW DR. ANNAPOLIS, MD</b>  |  |   |   |  |   |               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>HEPATORENAL SYNDROME</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>METASTATIC HEPATIC CARCINOMA</b>  |  |  |  |   |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 hrs</b><br><b>2 1/2 weeks</b><br><b>2 months</b> |               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>0</b>   |  |  |  |   |  |   |   |  |   |               |  |
| 19a. DATE OF OPERATION<br><b>NONE</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |   |  |   |               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |  |   |               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/16</b> , 19 <b>84</b> , to <b>11/6</b> , 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>11/6</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |   |  |   |               |  |
| 22b. SIGNATURE<br><b>Brenda C. McClain M.D.</b>   |  |  |  | DEGREE<br><b>M.D.</b>   |  |   |   | 22c. DATE SIGNED<br><b>11/6/84</b>   |   |               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Brenda C. McClain, M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>The Johns Hopkins Hospital</b>   |  |   |   |  |   |               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>11/10/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HILLCREST MEM. GAR.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ANNAPOLIS A.A. MD</b>                    |   |  |   |               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HARDESTY FUNERAL HOME</b>  |  |  |  | 25. DATE REC'D. BY REGISTRAR<br><b>NOV 8 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>a. Wilson-Randall</b>                                    |   |  |   |               |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 4 3 0 2 1 0   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1- FOR STATE REGISTRAR  |  |  |  | REG. NO.  |  |   |  |
| 1 DECEASED NAME (TYPE OR PRINT) <b>Gladys V. Roberts</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>11/30/84</b>  |  |   |  |
| 3 SEX <b>F</b>  |  |  |  | 2b. HOUR <b>11:30a.m.</b>   |  |   |  |
| 4 RACE <b>W</b>   |  | 5 DATE OF BIRTH MONTH DAY YEAR <b>9 26 1903</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY) <b>81</b>  |  | IF UNDER 1 YEAR MONTHS DAYS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. City MD</b>   |  |
| 10 CITY OR TOWN OF DEATH <b>Balto. City, Md.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Siani Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  | 13a. STREET ADDRESS <b>21218 3407 Lake Montebello Dr.</b>   |  |   |  |
| 13a. STATE <b>Md.</b>   |  | 13b. COUNTY <b>Balto.</b>  |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13d. CITY OR TOWN   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST <b>William Francis Roberts</b>   |  |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Annie Elizabeth Henning</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>   |  | 16b. SOCIAL SECURITY NO <b>216-03-7578</b>   |  | 17 INFORMANT ADDRESS <b>Wesley Home, 2211 W. Rogers Avenue, 21209</b>   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>CORONARY ARTERY DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Years</b>                                     |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Acute</b>   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/29/84</b> to <b>11/30/84</b> , that (I) (we) last saw the deceased alive on <b>11/29/84</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE <b>Robert E. Roby M.D.</b>   |  |  |  | DEGREE <b>M.D.</b>  |  | 22c. DATE SIGNED <b>11-30-84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBERT E. ROBY, M.D.</b>   |  |  |  | 22e. ADDRESS <b>8817 Belair Road 21236</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>12/04/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie A.A. Md</b>  |  |
| 24 FUNERAL DIRECTOR NAME <b>Burgee-Henss Funeral Home</b> ADDRESS <b>3631 Falls Road 21211</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>DEC 3 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>   |  |

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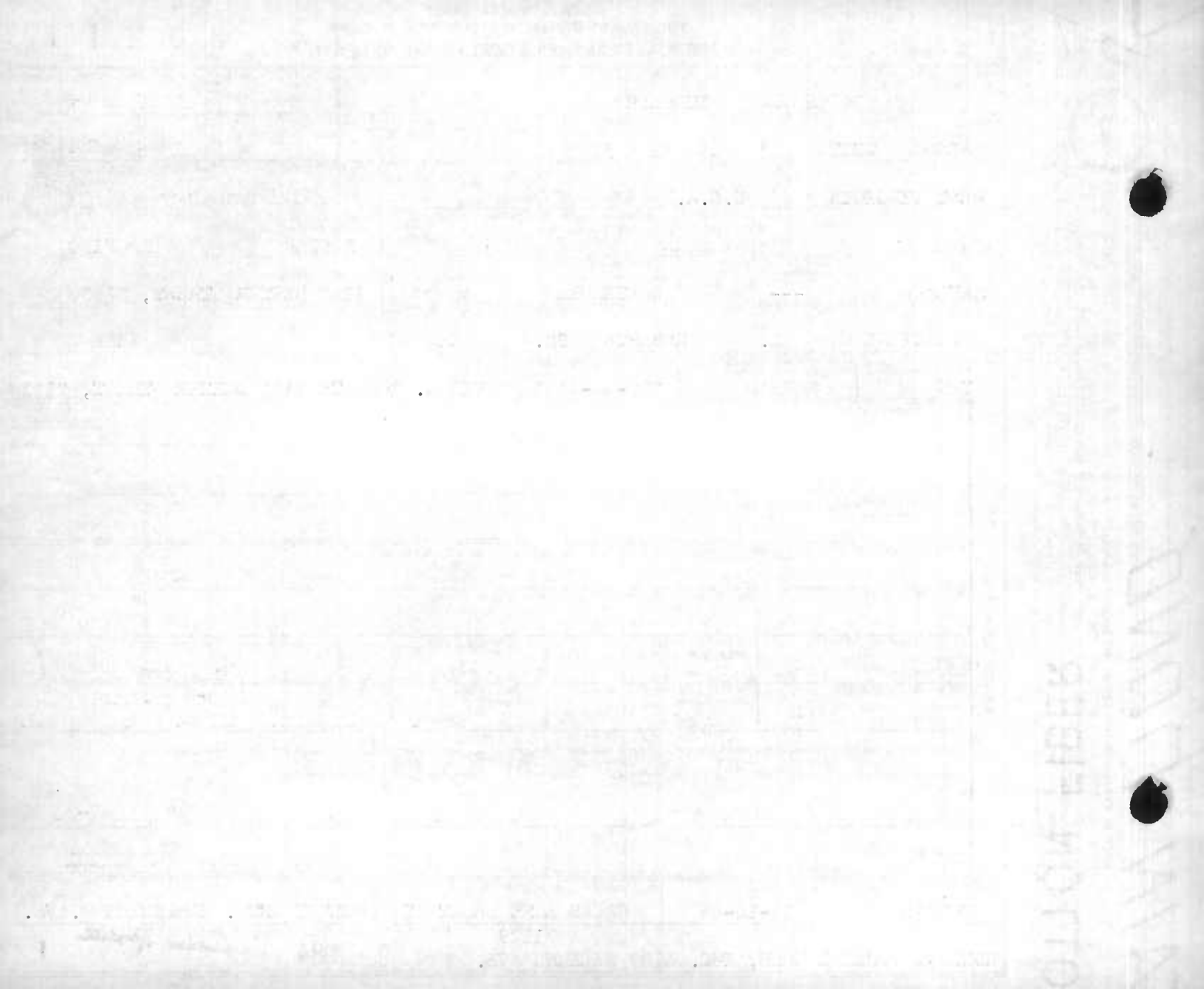
DHMH - 17  
(VR A15 ME (5))  
20M 4/82

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                      |   |   |                                    |   |   |  |  | REG. NO. 30211   |  |
|--|--|----------------------|---|---|------------------------------------|---|---|--|--|--|--|
| 1- FOR STATE REGISTRAR   |  |                      |   |   |                                    |   |   |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>PERCIVAL RUDOLPH ROBERTS</b>  |  |                      |   |   |                                    |   | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>11</b> DAY <b>6</b> YEAR <b>1984</b> |  | 2b. HOUR <b>9:15 PM</b>  |  |  |
| 3. SEX <b>MALE</b>   |  | 4. RACE <b>WHITE</b> |   | 5. DATE OF BIRTH<br>MONTH <b>11</b> DAY <b>05</b> YEAR <b>32</b>                      |                                    | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>52</b> YRS.   |   | IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b> |  | IF UNDER 24 HRS. HOURS <b></b> MIN <b></b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WEST VIRGINIA</b>   |  |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |   |                                    | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>   |  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  |                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hospital (STU)</b> |   |                                    |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>ROOFER</b>                               |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>ROOFING</b>   |  |
| 13a. STATE <b>MARYLAND</b>   |  |                      | 13b. COUNTY <b>---</b>  |   | 13c. CITY OR TOWN <b>BALTIMORE</b> |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>              |  | 13e. STREET ADDRESS <b>1142 DEXTER STREET, 21230</b>   |  |  |
| 14. FATHER'S NAME<br>FIRST <b>PERCIVAL</b> MIDDLE <b>R.</b> LAST <b>ROBERTS SR.</b>  |  |                      |   |   |                                    | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>BESSIE</b> MIDDLE <b></b> LAST <b>SEEL</b>   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>YES</b>   |  |                      |   | 16b. SOCIAL SECURITY NO. <b>232-48-2442</b>   |                                    | 17. INFORMANT <b>AVIS M. ROBERTS</b> ADDRESS <b>1142 DEXTER STREET, 21230</b>   |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>8150</b> IMMEDIATE CAUSE (a) <b>Multiple injuries</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last<br>(b) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b> |  |                      |   |   |                                    |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                      |   |   |                                    |   |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  |                      |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                     |                                    |   |   |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                      |   | 21b. TIME OF INJURY<br>HOUR <b>6:10</b> MONTH <b>11</b> DAY <b>6</b> YEAR <b>1984</b> |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Driver in collision with fixed objects and another auto.</b>            |   |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>   |  |                      |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>road</b>            |                                    | 21f. LOCATION<br>STREET <b>Wash. Blvd. &amp; Monroe St., Balto. City,</b> CITY OR TOWN <b>Balto. City,</b> COUNTY <b>BALTO.</b> STATE <b>MD.</b>            |   |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |  |                      |   |   |                                    |   |   |  |  | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |
| ACTUAL SIGNATURE <b>Ann M. Dixon</b>   |  |                      |   | TITLE (SPECIFY)<br>M.D. <b>Assistant</b>  |                                    |   |   | DATE SIGNED <b>11-7-84</b>                 |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>  |  |                      |   | ADDRESS <b>111 Penn St., Balto., Md. 21201</b>  |                                    |   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |  |                      |   | 23b. DATE <b>11-10-84</b>   |                                    | 23c. NAME OF CEMETERY OR CREMATORY <b>GREEN LANE CEMETERY</b>   |   |  | 23d. LOCATION<br>CITY OR TOWN <b>DELRAY HGTS. HAMPSHIRE W. VA.</b> COUNTY <b></b> STATE <b>VA.</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.</b> ADDRESS <b>21229</b>  |  |                      |   |   |                                    | 25a. DATE REC'D. BY REGISTRAR <b>NOV 9 1984</b>   |   |  | 25b. REGISTRAR'S SIGNATURE <b>Davidson</b>   |  |  |

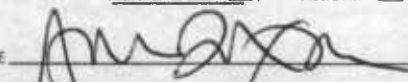
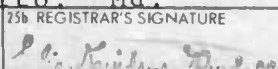




STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

30212

|   |  |                         |  |  |  |   |  |   |  |   |  |   |  |                                   |  |
|---|--|-------------------------|--|--|--|---|--|---|--|---|--|---|--|-----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ALBERT C. ROBINS Jr.</b>  |  |                         |  |  |  |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>11 11 1984</b>        |  | 2b. HOUR<br>M<br><b>4:08 a.m.</b>   |  |                                   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 25 32</b>   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>51 YRS.</b>  |  | IF UNDER 1 YR.<br>MONTHS DAYS<br><b>0 0 0</b>   |  | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>0 0</b>  |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>11 11 1984</b>                     |  |                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto. Md.</b>  |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>                       |  | MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>339 Bloom St.</b> |  |   |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |                         |  |  |  |   |  |   |  |   |  |   |  |                                   |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY             |  | 13c. CITY OR TOWN<br><b>Balto.</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>339 Bloom St. 2-A 21217</b>   |  |   |  |   |  |                                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Albert C. Robins Sr.</b>   |  |                         |  |  |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ruth Robins</b>   |  |   |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>  |  |                         |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)  |  | 17. INFORMANT ADDRESS<br><b>Mattie Horton 339 Bloom St. 21217</b>                               |  |   |  |   |  |   |  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypertensive cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |                         |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |                                   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |                         |  |  |  |   |  |   |  |   |  |   |  |                                   |  |
| 19a. DATE OF OPERATION  |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |   |  |   |  |                                   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |                                   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                         |  |  |  |   |  |   |  |   |  |   |  |                                   |  |
| ACTUAL SIGNATURE<br>   |  |                         |  |  |  | TITLE (SPECIFY)<br><b>Assistant</b>   |  |   |  | DATE SIGNED<br><b>11-11-84</b>  |  |   |  |                                   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Ann M. Dixon, M.D.</b>  |  |                         |  |  |  | ADDRESS<br><b>111 Penn St., Balto., Md. 21201</b>   |  |   |  |   |  |   |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |                         |  | 23b. DATE<br><b>11-17-84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Park</b>                                  |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>   |  |   |  |                                   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Ave.</b>  |  |                         |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 14 1984</b>   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br> |  |   |  |                                   |  |

BP  
DHMH - 17  
(VR A15 ME (5))

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

POST OFFICE BOX 1

CHATELAIN

PO BOX 1

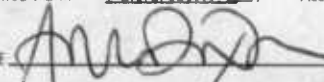
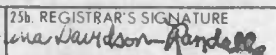


*[Handwritten signature]*

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                         |  |   |  |   |  |   |  | REG. NO. 30213   |  |
|---|--|-------------------------|--|---|--|---|--|---|--|--|--|
| 1- FOR STATE REGISTRAR  |  |                         |  |   |  |   |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JAMES ROBINSON</b>   |  |                         |  |   |  |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>EST. MATED <input checked="" type="checkbox"/> 11 21 1984 |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 14 21</b>  |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) YRS.<br><b>63</b>                        |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>11 27 1984</b>   |  | 2b. HOUR<br>M<br><b>noon</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2107 Booth St.</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MD</b>   |  |                         |  | 13b. COUNTY<br><b>Baltimore</b>   |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>2107 W. Booth St. 21217</b>                                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Robinson</b>   |  |                         |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Fannie Boarden</b>        |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>No</b>   |  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>212-14-1374</b>  |  | 17. INFORMANT ADDRESS<br><b>Louis Greene 4027 N. Rogers Ave.</b>              |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |                         |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |  |                         |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                         |  |   |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE   |  |                         |  |   |  | TITLE (SPECIFY)<br>M.D. <b>Assistant</b> MEDICAL EXAMINER                     |  | DATE SIGNED <b>11-28-84</b>   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>   |  |                         |  |   |  | ADDRESS <b>111 Penn St., Balto., Md. 21201</b>                                |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |                         |  | 23b. DATE<br><b>12/7/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Zion Cem.</b>                    |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD</b>                    |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Wm. C. March F/H</b>  |  |                         |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 7 1984</b>                            |  | 25b. REGISTRAR'S SIGNATURE<br>   |  |  |  |

20% COTTON FIBER

CHIEFLY MARKED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST  | MIDDLE | LAST   | 2a. DATE OF DEATH |   |  |  | 2b. HOUR |  |          |
|--|--|--|--------|--|-------------------|---|--|--|----------|--|----------|
| LAWRENCE   |  |  |        | ROBINSON JR.   |                   |   |  | 11   | 22       | 84   | 2:35P.M. |
| 3. SEX   |  | 4. RACE  |        | 5. DATE OF BIRTH   |                   | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR  |          | IF UNDER 24 HRS.                             |          |
| Male   |  | Black  |        | 8 25 12  |                   | 75 72 YRS.  |  | MONTHS DAYS  |          | HOURS MIN.                                   |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                   | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |          |  |          |
| MD   |  | USA  |        |  |                   | Baltimore City MD.  |  |  |          |  |          |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |        |  |                   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |          |  |          |
| City BALTO.  |  | Bon Secour Hospital  |        |  |                   |   |  |  |          |  |          |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b. COUNTY  |        | 13c. CITY OR TOWN  |                   | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS / ZIP CODE                                 |          |  |          |
| MD   |  |  |        | Baltimore  |                   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 429 N. Madeira St. 21231                                       |          |  |          |
| 14. FATHER'S NAME  |  |  |        | 15. MOTHER'S MAIDEN NAME   |                   |   |  |  |          |  |          |
| FIRST MIDDLE LAST<br>Lawrence Robinson   |  |  |        | FIRST MIDDLE LAST<br>Irene Robinson  |                   |   |  |  |          |  |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |        | 17. INFORMANT  |                   | ADDRESS   |  |  |          |  |          |
| No   |  | 212-12-4555  |        | Irene Robinson   |                   | 429 N. Madeira St.  |  |  |          |  |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  |  |  |        |  |                   |   |  |  |          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |          |
| IMMEDIATE CAUSE (a) CIRRHOSIS of liver   |  |  |        |  |                   |   |  |  |          |  |          |
| DUE TO, OR AS A CONSEQUENCE OF (b) with marked Ascities  |  |  |        |  |                   |   |  |  |          |  |          |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |        |  |                   |   |  |  |          |  |          |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |        |  |                   |   |  |  |          |  |          |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a   |  |  |        |  |                   |   |  |  |          |  |          |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |        |  |                   | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |          |  |          |
|  |  |  |        |  |                   | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |          |  |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY  |        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)   |                   |   |  |  |          |  |          |
|  |  | HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |        |  |                   |   |  |  |          |  |          |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |        | 21f. LOCATION  |                   | CITY OR TOWN  |  | COUNTY   |          | STATE  |          |
| WHILE <input type="checkbox"/> NO: WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |        | 11/5 84  |                   | 11/22   |  | 84   |          |  |          |
| 22a. I certify that (I) (the hospital) attended the deceased from 11/22 1984, saw the deceased alive on 11/22 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |        |  |                   |   |  |  |          |  |          |
| 22b. SIGNATURE   |  |  |        | DEGREE   |                   |   |  | 22c. DATE SIGNED   |          |  |          |
| Kuang-Yen Huang  |  |  |        | MD   |                   |   |  | 11/23/84   |          |  |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |        | 22e. ADDRESS   |                   |   |  |  |          |  |          |
| KUANG-YEN HUANG  |  |  |        | BON Secours Hospital   |                   |   |  |  |          |  |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |        | 23c. NAME OF CEMETERY OR CREMATORY   |                   | 23d. LOCATION   |  | CITY OR TOWN   |          | COUNTY                                       |          |
| Burial   |  | 11/28/84   |        | Mt. Auburn Cem.  |                   | Baltimore   |  |  |          | MD   |          |
| 24. FUNERAL DIRECTOR   |  |  |        |  |                   | 25a. DATE REC'D. BY REGISTRAR                                       |  | 25b. REGISTRAR'S SIGNATURE                                     |          |  |          |
| Wm. C. March F/H 1101 E. North Ave.  |  |  |        |  |                   | NOV 26 1984   |  | Julia Davidson-Randall   |          |  |          |





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                          |  |   |  |   |  |   |  | REG. NO. 30215   |  |
|---|--|--------------------------|--|---|--|---|--|---|--|--|--|
| 1- FOR STATE REGISTRAR  |  |                          |  |   |  |   |  |   |  | 2a. DATE OF DEATH  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>RICHARD L. ROBINSON   |  |                          |  |   |  |   |  |   |  | XX MONTH DAY YEAR<br>July 21 19 84                             |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Black         |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 20 32   |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>52 YRS.   |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |  | 7c. DATE PRONOUNCED DEAD<br>July 21 19 84 9:51P                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Baltimore  |  |                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.  |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.     |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  |                          |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Laborer  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Steel                     |  |
| 13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |                          |  |   |  |   |  |   |  |  |  |
| 13a. STATE<br>Md.   |  | 13b. COUNTY<br>Baltimore |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>1436 Argyle Ave. 21217   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Richard Robinson  |  |                          |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Jackson                                   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>Yes  |  |                          |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>Korean   |  | 17. INFORMANT ADDRESS<br>Mary Robinson (Wife) s/a   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4292 Arteriosclerotic cardiovascular disease<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) DUE TO, OR AS A CONSEQUENCE OF   |  |                          |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1  |  |                          |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                          |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                          |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Medical causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Reissued: |  |                          |  |   |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE<br>Thomas D. Smith, M.D.   |  |                          |  | TITLE (SPECIFY)<br>Deputy Chief   |  |   |  | DATE SIGNED<br>11/26/84   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Thomas D. Smith, M.D.  |  |                          |  | ADDRESS<br>111 Penn Street, Balto. MD 21201   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |                          |  | 23b. DATE<br>7/27/84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Crownsville V.A. Cem                                      |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Crownsville, Md. |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Brown/Thompson F. H. 1913 W. Baltimore St.  |  |                          |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 27 1984  |  | 25b. REGISTRAR'S SIGNATURE<br>Davidson-Rendell  |  |  |  |

BP

Page 7 of 7  
Date: 10/10/2011

Mr. [Name] [Address]  
[City] [State] [Zip]  
[Phone Number]  
[Email Address]



Printed: 10/10/2011  
Page 7 of 7

**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

|  |  |         |  |   |  |                   |  |  |  |                     |  |   |  |           |  |                            |  |  |  |
|--|--|---------|--|---|--|-------------------|--|--|--|---------------------|--|---|--|-----------|--|----------------------------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |         |  | 2a. DATE KNOWN OF DEATH   |  |                   |  | 3. DATE OF DEATH   |  |                     |  | 4. HOUR   |  |           |  |                            |  |  |  |
| SAMUEL   |  |         |  | ROBINSON  |  |                   |  | 11   |  |                     |  | 19 19 84  |  |           |  |                            |  |  |  |
| 3. SEX   |  | 4. RACE |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS) |  | 7. IF UNDER 1 YR.  |  | 8. IF UNDER 24 HRS. |  | 9. DATE PRONOUNCED DEAD   |  | 10. HOUR  |  |                            |  |  |  |
| Male   |  | Black   |  | 4-19-25   |  | 59 YRS.           |  |  |  |                     |  | 11 19 19 84   |  | 6:10 a.m. |  |                            |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |         |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |                   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                     |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |           |  |                            |  |  |  |
| MD.  |  |         |  | USA   |  |                   |  |  |  |                     |  | Baltimore City MD.  |  |           |  |                            |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |                     |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |           |  |                            |  |  |  |
| Baltimore  |  |         |  | 818 Carroll St.   |  |                   |  | Labor  |  |                     |  | Beth. Steel   |  |           |  |                            |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |         |  |   |  |                   |  |  |  |                     |  |   |  |           |  |                            |  |  |  |
| 13a. STATE   |  |         |  | 13b. COUNTY   |  |                   |  | 13c. CITY OR TOWN  |  |                     |  | 13d. INSIDE CITY LIMITS?  |  |           |  |                            |  |  |  |
| MD.  |  |         |  |   |  |                   |  | Balto  |  |                     |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |           |  |                            |  |  |  |
| 14. FATHER'S NAME  |  |         |  | 15. MOTHER'S MAIDEN NAME  |  |                   |  |  |  |                     |  |   |  |           |  |                            |  |  |  |
| Willie Robinson  |  |         |  | Missouri Robinson   |  |                   |  |  |  |                     |  |   |  |           |  |                            |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |  |         |  | 16b. SOCIAL SECURITY NO.  |  |                   |  | 17. INFORMANT ADDRESS  |  |                     |  |   |  |           |  |                            |  |  |  |
| Yes  |  |         |  | 218-26-4376   |  |                   |  | Hattie Robinson 1803 Druid Hill Ave.   |  |                     |  |   |  |           |  |                            |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |         |  |   |  |                   |  |  |  |                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |           |  |                            |  |  |  |
| PART I DEATH WAS CAUSED BY:  |  |         |  |   |  |                   |  |  |  |                     |  |   |  |           |  |                            |  |  |  |
| IMMEDIATE CAUSE (a) Hypertensive and arteriosclerotic cardiovascular   |  |         |  |   |  |                   |  |  |  |                     |  |   |  |           |  |                            |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |         |  |   |  |                   |  |  |  |                     |  |   |  |           |  |                            |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |  |         |  |   |  |                   |  |  |  |                     |  |   |  |           |  |                            |  |  |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF   |  |         |  |   |  |                   |  |  |  |                     |  |   |  |           |  |                            |  |  |  |
| (c)  |  |         |  |   |  |                   |  |  |  |                     |  |   |  |           |  |                            |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |         |  |   |  |                   |  |  |  |                     |  |   |  |           |  |                            |  |  |  |
| 19a. DATE OF OPERATION   |  |         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |                   |  |  |  |                     |  | 20. AUTOPSY?  |  |           |  |                            |  |  |  |
|  |  |         |  |   |  |                   |  |  |  |                     |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |           |  |                            |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |         |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  |  |                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |                     |  |   |  |           |  |                            |  |  |  |
|  |  |         |  | P.M. 19   |  |                   |  |  |  |                     |  |   |  |           |  |                            |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |                   |  | 21f. LOCATION  |  |                     |  |   |  |           |  |                            |  |  |  |
|  |  |         |  |   |  |                   |  | CITY OR TOWN COUNTY STATE  |  |                     |  |   |  |           |  |                            |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |         |  |   |  |                   |  |  |  |                     |  |   |  |           |  |                            |  |  |  |
| ACTUAL SIGNATURE   |  |         |  |   |  |                   |  |  |  |                     |  | TITLE (SPECIFY)   |  |           |  | DATE SIGNED                |  |  |  |
| Ann M. Dixon, M.D.   |  |         |  |   |  |                   |  |  |  |                     |  | M.D. Assistant  |  |           |  | 11-19-84                   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  |         |  |   |  |                   |  |  |  |                     |  | ADDRESS   |  |           |  |                            |  |  |  |
| Ann M. Dixon, M.D.   |  |         |  |   |  |                   |  |  |  |                     |  | 111 Penn St., Balto., Md. 21201                                     |  |           |  |                            |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |         |  | 23b. DATE   |  |                   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |                     |  | 23d. LOCATION   |  |           |  |                            |  |  |  |
| Burial   |  |         |  | 11-24-84  |  |                   |  | King, s Mem. Pk.   |  |                     |  | Randallstown MD.  |  |           |  |                            |  |  |  |
| 24. FUNERAL DIRECTOR NAME  |  |         |  |   |  |                   |  |  |  |                     |  | 25a. DATE REC'D. BY REGISTRAR                                       |  |           |  | 25b. REGISTRAR'S SIGNATURE |  |  |  |
| Chas. A. Rice FSPA 1300 Eutaw Place  |  |         |  |   |  |                   |  |  |  |                     |  | NOV 26 1984   |  |           |  | Julia Davidson             |  |  |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

NO TO 100% COTTON

CHIEFMAN

AND

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

30217  
REG. NO.

FOR  
1- STATE  
REGISTRAR

|  |         |  |  |  |  |   |  |  |  |                          |  |        |  |       |  |          |  |
|--|---------|--|--|--|--|---|--|--|--|--------------------------|--|--------|--|-------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST  |  | MIDDLE   |  | LAST  |  | 2a. DATE KNOWN OF DEATH                      |  | MONTH                    |  | DAY    |  | YEAR  |  | 2b. HOUR |  |
| WILLIAM  |         |  |  |  |  | RODE  |  | xx   |  | 11                       |  | 20     |  | 84    |  | am       |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)  |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.                             |  | 7c. DATE PRONOUNCED DEAD |  | MONTH  |  | DAY   |  | YEAR     |  |
| Male   | White   | 11/26/84   |  | 79 YRS.  |  |   |  |  |  | 11-26-84                 |  |        |  |       |  | 11:44    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED   |  | NEVER MARRIED   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH         |  |                          |  |        |  |       |  |          |  |
| Maryland   |         | U.S.   |  | WIDOWED  |  | DIVORCED  |  | Baltimore City                               |  |                          |  |        |  |       |  | MD.      |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |                          |  |        |  |       |  |          |  |
| Baltimore  |         | 201 N. Washington Street #502  |  |  |  |   |  |  |  |                          |  |        |  |       |  |          |  |
| 13a. STATE   |         | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS                          |  |                          |  |        |  |       |  |          |  |
| Md.  |         |  |  | Balto.   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 201 N. Washington St.                        |  |                          |  |        |  |       |  | 21231    |  |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME   |  |  |  |   |  |  |  |                          |  |        |  |       |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |         | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS   |  |  |  |                          |  |        |  |       |  |          |  |
| No   |         |  |  |  |  |   |  |  |  |                          |  |        |  |       |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         | PART I DEATH WAS CAUSED BY:  |  | IMMEDIATE CAUSE (a)  |  | Arteriosclerotic cardiovascular disease                             |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                          |  |        |  |       |  |          |  |
|  |         |  |  | (b)  |  | DUE TO, OR AS A CONSEQUENCE OF                                      |  |  |  |                          |  |        |  |       |  |          |  |
|  |         |  |  | (c)  |  | DUE TO, OR AS A CONSEQUENCE OF                                      |  |  |  |                          |  |        |  |       |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                       |         |  |  |  |  |   |  |  |  |                          |  |        |  |       |  |          |  |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?   |  |   |  |  |  |                          |  |        |  |       |  |          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                           |         | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |  |  |                          |  |        |  |       |  |          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION  |  |   |  |  |  |                          |  |        |  |       |  |          |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from:   |         | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |   |  |  |  |                          |  |        |  |       |  |          |  |
| ACTUAL SIGNATURE   |         | M.D.   |  | TITLE (SPECIFY)  |  | DATE  |  |  |  |                          |  |        |  |       |  |          |  |
| Margarita A. Korell, M.D.  |         | 111 Penn Street  |  | Assistant  |  | 11-27-84  |  |  |  |                          |  |        |  |       |  |          |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |         | ADDRESS  |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY           |  | 23d. LOCATION            |  |        |  |       |  |          |  |
|  |         |  |  | Removal  |  | 12/5/84   |  |  |  | CITY OR TOWN             |  | COUNTY |  | STATE |  |          |  |
| 24. FUNERAL DIRECTOR   |         | NAME   |  | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR                                       |  | 25b. REGISTRAR'S SIGNATURE                   |  |                          |  |        |  |       |  |          |  |
| Anatomy Board  |         | Balto., Md.  |  |  |  | 11-23-84  |  |  |  |                          |  |        |  |       |  |          |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

1987 OCT 10

1000 MINERAL

(212)

FOR STATE  
HEALTH DEPT.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|   |         |                              |  |  |                                    |  |  |                              |   |  |                             |  |       |  |
|---|---------|------------------------------|--|--|------------------------------------|--|--|------------------------------|---|--|-----------------------------|--|-------|--|
| DECEASED NAME<br>(Type or Print)  |         |                              | First Middle Last  |  |                                    | 2a. DATE KNOWN OF DEATH  |  |                              | Month Day Year                                  |  |                             | 2b. HOUR                                     |       |  |
| SAMUEL R. ROGERS, SR.   |         |                              |  |  |                                    | <input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year |  |                              | 11-30 1984                                      |  |                             | 1210   |       |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH             | 6. AGE (In years last birthday)  | IF UNDER 1 YEAR  |                                    | IF UNDER 24 HRS.   |  | 2c. DATE PRONOUNCED DEAD     |   |  | 2d. HOUR                    |  |       |  |
| M   | W       | 3-21-1920                    | 64 YRS.  | MONTHS   | DAYS                               | HOURS  | MIN.   | Month 12 Day 1 Year 1984     |   |  | 1210                        |  |       |  |
| 7a. BIRTHPLACE (State or foreign country)   |         | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. COUNTY OF DEATH   |  |                              |   |  |                             |  |       |  |
| WEST VIRGINIA   |         | U. S. A.                     |  |  |                                    | BALTIMORE City Md.   |  |                              |   |  |                             |  |       |  |
| 10. CITY OR TOWN OF DEATH   |         |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |                                    | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)              |  |                              | 12b. KIND OF BUSINESS OR INDUSTRY               |  |                             |  |       |  |
| BALTIMORE   |         |                              | 2915 EASTERN AVE.  |  |                                    | PLUMBER  |  |                              | PLUMBING  |  |                             |  |       |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |         |                              | 13b. COUNTY  |  | 13c. CITY OR TOWN                  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                              | 13e. STREET AND NUMBER                          |  |                             |  |       |  |
| MD.   |         |                              | BALTO.   |  | BALTO.                             |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                          |                              | 2915 EASTERN AVE. 21220                         |  |                             |  |       |  |
| 14. FATHER'S NAME   |         |                              | 15. MOTHER'S MAIDEN NAME   |  |                                    |  |  |                              |   |  |                             |  |       |  |
| First Middle Last   |         |                              | First Middle Last  |  |                                    |  |  |                              |   |  |                             |  |       |  |
| ROBERT A. ROGERS  |         |                              | IDA BELL BUTTERWORTH   |  |                                    |  |  |                              |   |  |                             |  |       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |         |                              | 16b. SOCIAL SECURITY NO.   |  |                                    | 17. INFORMANT  |  |                              | ADDRESS   |  |                             |  |       |  |
| YES   |         |                              | W. W. II   |  |                                    | 233-24-2023  |  |                              | Mrs. Janette E. Lennard - 4 Duralumin Ct. 21220 |  |                             |  |       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         |                              |  |  |                                    |  |  |                              |   |  |                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |       |  |
| PART 1. DEATH WAS CAUSED BY:  |         |                              |  |  |                                    |  |  |                              |   |  |                             | 6 mos  |       |  |
| IMMEDIATE CAUSE (a) <u>Carcinoma of the lung</u>  |         |                              |  |  |                                    |  |  |                              |   |  |                             |  |       |  |
| DUE TO, OR AS A CONSEQUENCE OF  |         |                              |  |  |                                    |  |  |                              |   |  |                             |  |       |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |         |                              |  |  |                                    |  |  |                              |   |  |                             |  |       |  |
| (b) _____   |         |                              |  |  |                                    |  |  |                              |   |  |                             |  |       |  |
| DUE TO, OR AS A CONSEQUENCE OF  |         |                              |  |  |                                    |  |  |                              |   |  |                             |  |       |  |
| (c) _____   |         |                              |  |  |                                    |  |  |                              |   |  |                             |  |       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |         |                              |  |  |                                    |  |  |                              |   |  |                             |  |       |  |
| 19a. DATE OF OPERATION  |         |                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                                    |  |  |                              |   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                             |  |       |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         |                              | 21b. TIME OF INJURY Month, Day, Year   |  |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                      |  |                              |   |  |                             |  |       |  |
|   |         |                              | HOUR A.M. P.M. 19  |  |                                    |  |  |                              |   |  |                             |  |       |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |         |                              | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  |                                    | 21f. LOCATION Street or R.F.D. No.   |  |                              | City or Town                                    |  | County                      |  | State |  |
|   |         |                              |  |  |                                    |  |  |                              |   |  |                             |  |       |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |                              |  |  |                                    |  |  |                              |   |  |                             |  |       |  |
| ACTUAL SIGNATURE  |         |                              | CHIEF MEDICAL EXAMINER   |  |                                    |  |  |                              | 22b. DATE SIGNED                                |  |                             |  |       |  |
| T. Crossman O'Donovan   |         |                              |  |  |                                    |  |  |                              | 12-1-84   |  |                             |  |       |  |
| EXAMINER'S NAME (Type)  |         |                              | ASSISTANT MEDICAL EXAMINER   |  |                                    |  |  |                              |   |  |                             |  |       |  |
| T. CROSSMAN O'DONOVAN   |         |                              | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                  |  |                                    |  |  |                              |   |  |                             |  |       |  |
|   |         |                              | ADDRESS (Street, city, town, or county)                                      |  |                                    |  |  |                              |   |  |                             |  |       |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |         |                              | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |  |  | 23d. LOCATION (City or Town) |   | (County)   |                             | (State)                                      |       |  |
| BURIAL  |         |                              | 12-3-84  |  | HOLLY HILLS CEM.                   |  |  | BALTO. Md.                   |   |  |                             |  |       |  |
| 24. FUNERAL DIRECTOR  |         |                              | ADDRESS  |  |                                    |  |  |                              | 25a. REC'D BY REGISTRAR                         |  | 25b. SIGNATURE OF REGISTRAR |  |       |  |
| Faithy Miller   |         |                              |  |  |                                    |  |  |                              | DATE  |  |                             |  |       |  |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages listed 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201





MECHANICAL ENGINEERING DEPARTMENT  
UNIVERSITY OF CALIFORNIA  
SAN DIEGO  
CALIFORNIA 92161  
U.S.A.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 4 3 0 2 1 9   |  |
|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>HOWARD</b>   |  | MIDDLE<br><b>M.</b>  |  | LAST<br><b>ROLLINS</b>  |  |
| 3. SEX<br><b>MALE</b><br><i>m</i>   |  | 4. RACE<br><b>NEGRO</b><br><i>B</i>  |  | 5. DATE OF BIRTH<br><b>JAN. 28 1899</b><br><i>1 29 99</i>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO City</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Lutheran HOSPITAL</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALT City</b> MD.  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>POSTAL CLERK</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. P.O.</b>  |  | 12c. DATE SIGNED<br><b>11-3-84</b>  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  |
| 14. FATHER'S NAME (FIRST MIDDLE LAST)<br><b>HORACE</b>  |  | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)<br><b>LOTTIE EVANS</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>220-38-6196</b>   |  | 17. INFORMANT ADDRESS<br><b>MELVIN T. ROLLINS 1532 LOCHWOOD ROAD BALTO., Md. 21218</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Dysrhythmia</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>CHF</b>   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10-31-84</b> , 19 <b>84</b> , to <b>11-3-</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>11-3-</b> 19 <b>84</b> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |
| 22b. SIGNATURE<br><i>Susan And</i>  |  | DEGREE<br><i>MD</i>  |  | 22c. DATE SIGNED<br><b>11-3-84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SISSAY Awoka</b>  |  | 22e. ADDRESS<br><b>Lutheran Hospital</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>11/08/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ARBUTUS MEM PARK</b>   |  |
| 24. FUNERAL DIRECTOR (NAME)<br><b>MARSHALL W. JONES, JR.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 7 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Richard M. Andell</i>  |  |
| 4101 EDMONDSON AVE./BALTO., Md. 21229   |  | BALTIMORE BALTO., Md.  |  |   |  |

BP

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X

RELEASED NON MED DR KAUFFMAN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 are to be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP  
DHMH - 16 50M 4/83  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |  |  |  |  |
|---|--|---|--|---|--|--|--|--|--|--|--|
| FOR<br>1. STATE<br>REGISTRAR  |  | REG. NO. 8 4 3 0 2 2 0  |  |   |  |  |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br>CURTIS   |  | MIDDLE  |  | LAST<br>ROSEBOUGH<br>(ROSEBORO)  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  | 2b. HOUR   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 12 17   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>67 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>S.C.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                           |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |  |   |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                        |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD   |  | 13b. COUNTY<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE<br>1102 N. Port St. 21213                             |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Walter Rosebough  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Alice Bishop   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>248-05-6993  |  | 17. INFORMANT ADDRESS<br>Evelyn Shuler 2612 E. Chase St.   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.           |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>18 hours |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:<br><u>Alcohol abuse</u>  |  |   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/11/84</u> , 19 <u>84</u> , to <u>11/12</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>11/12</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Marc Litt</u>  |  | DEGREE<br>MD  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br>11/13/84   |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Marc Litt  |  | 22e. ADDRESS<br>Johns Hopkins Hospital Baltimore  |  |   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>11/17/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Zion Cem.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore MD                           |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H 1101 E. North Ave.   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>16 1984   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Richard Davidson-Randall</u>  |  |  |  |

MEDICAL CERTIFICATION



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 30221

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH  |  | 2b. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | MONTH DAY YEAR   |  | 11-9-84 11:46 AM  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  |
| M   |  | W  |  | MONTH DAY YEAR  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| Baltimore, MD   |  | USA  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |
| Baltimore   |  | Lutheran Hospital of Md.   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. STREET ADDRESS   |  |
| MD  |  | Baltimore  |  | 2026 Hollins St 21223   |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |
| FIRST MIDDLE LAST   |  | FIRST MIDDLE LAST  |  |   |  |
| UNK   |  | UNK  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS   |  |
| YES   |  | 218-05-1051  |  | Betsy Hall 2026 Hollins St  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Cardiac arrest  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Multiple organ failure   |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic Cardiovascular Disease   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |  |  |   |  |
| ① Femur - Fractured by fall 1 renal failure 1 respiratory failure   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  |
| 11-2-84   |  | Gangrene @ foot  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
|   |  | P.M. 19  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
|   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/2/84 19, to 11/9/84 19, that (I) (we) last saw the deceased alive on 11/9/84 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |
| 22b. SIGNATURE  |  | DEGREE   |  | 22c. DATE SIGNED  |  |
| [Signature]   |  |  |  | 11/9/84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |   |  |
| PELAYO E. CORREA  |  | LUTHERAN HOSPITAL  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |
| Burial  |  | 11/15/84   |  | MD VERONAS  |  |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |
| [Signature]   |  | NOV 13 1984  |  | [Signature]   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Final may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of price.

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Raphael V. Ross   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>11-23-84  |  |
| 3. SEX<br>Male   | 4. RACE<br>Black   | 5. DATE OF BIRTH MONTH DAY YEAR<br>3-4-1916   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Baltimore   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Lutheran | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Machine operator   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br>MD.  | 13b. COUNTY  | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>UNK   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Pulley   | 13e. STREET ADDRESS<br>403 Normandy Avenue 21229  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>217-03-6630  | 17. INFORMANT ADDRESS<br>Mrs. Thelma Ross 403 Normandy Ave.   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Parkinsonism</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension</u> |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1975</u> 19 <u>84</u> , to <u>Nov</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>one week ago</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                   |  |   |  |
| 22b. SIGNATURE<br><u>[Signature]</u>   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        | 22c. DATE SIGNED<br>11/27/84   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>D.S. SAWHNEY  |  | 22e. ADDRESS<br>7422 BTA BVD GLEN-BURNIE MD 21061   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  | 23b. DATE<br>11-29-84  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Mem. Park   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore   |
| 24. FUNERAL DIRECTOR NAME<br>Brown / Thompson F.H. 1913 W. Balb. St.   |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br>NOV 30 1984 <u>[Signature]</u>  |  |



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1- STATE REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |                             |  |
|---|--|--|--|---|-----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>First: <u>Robert Thomas</u> Middle: <u>E.</u> Last: <u>Ross</u>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><u>11/24/84</u>   |   | 2b. HOUR<br><u>12:30 PM</u> |  |
| 3. SEX<br><u>Male</u>   |  | 4. RACE<br><u>Black</u>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><u>6/02/19</u>  |                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Virginia</u>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                             |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>City</u>   |  |  | 12b. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |   |                             |  |
| 10. CITY OR TOWN OF DEATH<br><u>Baltimore</u>   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>University of Md</u> |   |                             |  |
| 13a. STATE<br><u>md</u>   |  | 13b. COUNTY<br><u>Baltimore</u>  |  | 13c. CITY OR TOWN<br><u>Baltimore</u>   |                             |  |
| 14. FATHER'S NAME<br>First: <u>Charles</u> Middle: <u>Ross</u>  |  |  | 15. MOTHER'S MAIDEN NAME<br>First: <u>Estelle</u> Middle: <u>Freman</u>  |   |                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>Yes</u>  |  | 16b. SOCIAL SECURITY NO.<br><u>224-18-1092</u>   |  | 17. INFORMANT<br>NAME: <u>Emma Wms</u> ADDRESS: <u>2503 W. Pratt St. 21223</u>  |                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary collapse</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>probable sepsis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><u>Abdominal surgery for perforated bowel</u> |  |  |  |   |                             |  |
| 19a. DATE OF OPERATION<br><u>11/13/84</u>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>perforated bowel</u>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                             |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)<br>21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <u>19</u><br>21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |                             |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/13/84</u> to <u>11/24/84</u> , that (I) (we) last saw the deceased alive on <u>11/24/84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |                             |  |
| 22b. SIGNATURE<br><u>G. Fromell</u>   |  | DEGREE<br><u>MD</u>  |  | 22c. DATE SIGNED<br><u>11/24/84</u>   |                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>G. Fromell</u>  |  | 22e. ADDRESS<br><u>22 S. Green St. 21207</u>   |  |   |                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>  |  | 23b. DATE<br><u>11/30/84</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Garrison Forest V.A.</u>   |                             |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Owings Mills Md.</u>   |  | 24. FUNERAL DIRECTOR<br>NAME: <u>Wm. C. March F/H 1101 E. North Ave</u> ADDRESS: _____   |  |   |                             |  |
| 25a. DATE REC'D. BY REGISTRAR<br><u>NOV 28 1984</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Lelia Davidson</u>  |  |   |                             |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 4 3 0 2 2 4  
CERTIFICATE OF DEATH

| STATE REGISTRAR   |  |  |  | REG. NO.  |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WILLIE F ROSS</b>  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-8-84</b>   |  | 2b. HOUR<br><b>12:07 AM</b>  |  |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>B</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2-26-11</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALT.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BON SECOURS HOSP</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MD.</b>  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Edmond Ross</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Julia Matthews</b>   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>2018 PENROSE AVE ; 21223</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>217-01-3737</b>   |  | 17. INFORMANT ADDRESS<br><b>Beverly Ross-Burrell 2018 Penrose Ave</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hepato-renal failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>intrahepatic biliary obstruction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Ca pancreas &amp; metastasis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>11-6-84</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>hpn. laparotomy</b>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/27/84</b> 19____, to <b>11/8/84</b> 19____, that (I) (we) last saw the deceased alive on <b>11/8/84</b> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (do not) view the body after death.   |  |  |  |   |  |  |  |
| 23a. SIGNATURE<br><b>J. M. Hippolito</b>  |  | DEGREE<br><b>MD.</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>11/8/84</b>   |  |
| 23b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>J. M. HIPOLITO</b>  |  | 22e. ADDRESS<br><b>4209 Funderick Ave 21229</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11/12/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sutton Family Plot</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Edwardsville VA</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H 1101 E. North Ave.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>NOV 9 1984</b> <i>Davidson-Randall</i>   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination must be made.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| Item 11 per phone 11/30/84 dad   |  |  |  |  |  |  |  |  |  | STATE OF MARYLAND  |  |  |  |  |  |  |  |  |  |
| 1- FOR STATE REGISTRAR   |  |  |  |  |  |  |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  |  |  |  |  |  |
| CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  | 7 4 3 0 2 2 5  |  |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Clarence Wilbert Roten   |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>November 18, 1984  |  |  |  |  |  |  |  |  |  |
| 3 SEX<br>Male  |  |  |  |  |  |  |  |  |  | 2b. HOUR P M<br>11:22 P M  |  |  |  |  |  |  |  |  |  |
| 4. RACE<br>White   |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Nov. 25, 1918   |  |  |  |  |  |  |  |  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>65 YRS.   |  |  |  |  |  |  |  |  |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  |  |  |  |  |  |  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Sinai Hospital |  |  |  |  |  |  |  |  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Teacher   |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Balto. City Sch.  |  |  |  |  |  |  |  |  |  |
| 13a. STATE<br>Maryland   |  |  |  |  |  |  |  |  |  | 13b. COUNTY<br>Baltimore   |  |  |  |  |  |  |  |  |  |
| 13c. CITY OR TOWN<br>Towson  |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             |  |  |  |  |  |  |  |  |  |
| 13e. STREET ADDRESS / ZIP CODE<br>22 Lambourne Rd. 21204   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Wilbert O. Roten  |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>F. Mabel Bull  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.<br>705-14-0358  |  |  |  |  |  |  |  |  |  |
| 17. INFORMANT ADDRESS<br>Bettie Brodka 237A Burk Ave. Towson 21204   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIAC ARREST<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) ARTERIOSCLEROTIC HEART DISEASE WITH<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Two Previous Myocardial Infarctions<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>15-20 min.<br>46 months |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |  |  |  |  |  |  |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |  |  |  |  |  |  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  |  |  |  |  |  |  |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 01-01, 19 81, to 11-18, 19 84, that (I) (we) last saw the deceased alive on 09-11, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>Anthony A. Lewandowski M.D.  |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED<br>11-19-84   |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Anthony A. Lewandowski, Jr. M.D.  |  |  |  |  |  |  |  |  |  | 22e. ADDRESS<br>7402 York Rd. Baltimore, Md. 21212   |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |  |  |  |  |  |  |  |  | 23b. DATE<br>Nov. 23, 1984   |  |  |  |  |  |  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Middletown U.M. Cem.   |  |  |  |  |  |  |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Freeland, Balto. Co., Md.   |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>Mitchell-Wiedefeld Home, Inc.  |  |  |  |  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 27 1984   |  |  |  |  |  |  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br>P. J. ...  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |  |  |   |  |  | 8 4 3 0 2 2 6  |  |
|--|--|---|--|---|--|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   |  |  |   |  |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   |  |   | 2a. DATE OF DEATH                          |  |   |  |  | 2b. HOUR   |  |
| FIRST MIDDLE LAST<br><b>MARGARET ROUSH</b>   |  |   |  |   | MONTH DAY YEAR<br><b>NOVEMBER 29, 1984</b> |  |   |  |  | 7:40AM   |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |   | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS  |  |
| FEMALE   |  | WHITE   |  | MONTH DAY YEAR<br><b>OCT. 13, 1890</b>  |  | 94 YRS.  |   | MONTHS DAYS  |  | HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |   |  |  |  |  |
| OHIO   |  | U.S.A.  |  |   |  | BALTIMORE CITY, MD.  |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |   | 12b. KIND OF BUSINESS OR INDUSTRY                        |  |  |  |
| BALTIMORE  |  | EDGEWOOD NURSING HOME   |  |   |  | HOMEMAKER  |   | HOME   |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   | 13d. INSIDE CITY LIMITS?                   |  | 13e. STREET ADDRESS / ZIP CODE          |  |  |  |  |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 6808 COLLINSDALE RD. 21234                               |  |  |  |
| MARYLAND   |  | BALTIMORE   |  | 21234   |  |  |   |  |  |  |  |
| 14. FATHER'S NAME  |  |   |  |   | 15. MOTHER'S MAIDEN NAME                   |  |   |  |  |  |  |
| FIRST MIDDLE LAST<br><b>AMOS RIPLEY</b>  |  |   |  |   | FIRST MIDDLE LAST<br><b>M. F. SHIELDS</b>  |  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  |   |  |   | 16b. SOCIAL SECURITY NO.                   |  | 17. INFORMANT ADDRESS                   |  |  |  |  |
| NO   |  |   |  |   | 276-62-4841                                |  | WOODROW DILS 6808 COLLINSDALE RD. 21234 |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Atherosclerosis</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |  |   |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |   |  |   |  |  |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |   | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |   |  |   |  |  |   | YES <input type="checkbox"/> NO <input type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>MARCH 18, 1975</i> to <i>NOV. 29, 1984</i> , that (I) (we) lost saw the deceased alive on <i>Nov 23, 1984</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                         |  |   |  |   |  |  |   |  |  |  |  |
| 22b. SIGNATURE<br><i>William M. Smith M.D.</i>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |  |   | 22c. DATE SIGNED<br><i>11/29/84</i>                      |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  | 22e. ADDRESS  |  |  |   |  |  |  |  |
| MEREDITH SMITH, M.D.   |  |   |  | 5409 SPRINGLAKE WAY 435-5459  |  |  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE               |  |  |  |
| BURIAL   |  |   |  | DEC. 3, '84   |  | I.O.O.F. CEMETERY  |   | PARKERSBURG, WEST VIRGINIA                               |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  |   |  | ADDRESS   |  |  |   | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE |  |  |  |
| WILLIAM E. JOHNSON   |  |   |  | 8521 LOCH RAVEN BLVD.   |  |  |   | DEC 3 1984   |  |  |  |

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NOV 19 1954

TO : DIRECTOR, FBI

FROM : SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

DATE: 11-19-54

100-33417-1

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |   |   |  |   | 8 4 3 0 2 2 7  |  |
|--|---|---|--|---|--|--|
| 1. FOR STATE REGISTRAR   |   |   | REG. NO.   |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARY ROYSTON</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 6, 1984</b>                       |   | 2b. HOUR<br><b>1:30 P</b> M  |  |
| 3. SEX<br><b>FEMALE</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 18, 1900</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b> YRS.                                    |   | 7. UNDER 1 YEAR<br>MONTHS DAYS<br><b>83</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |  |
| 13a. STATE<br><b>Maryland</b>  |   | 13b. COUNTY<br><b>--</b>  | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>----- Schmidt</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>unknown</b>   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>215-52-0883</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>1705 Ingram Rd.<br/>Raymond M. Royston, Balto., MD 21239</b>     |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 10a, 10b, and 10c.)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b>  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3-5 days</b>  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause 10a, stating the underlying cause lost.   |   |   |  |   |  |  |
| (b) <b>SEPSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |   |   |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c).   |   |   |  |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost<br>saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |   |   |  |   |  |  |
| 22b. SIGNATURE<br><b>Mitchell J Cohen</b>  |   | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>11/6/84</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MITCHELL J COHEN</b>   |   | 22e. ADDRESS<br><b>4940 EASTERN AVE BALTO MD</b>  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>Nov 1984</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Zion Cemetery</b>                       |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Freeland, Balto, Co., MD</b>  |  |
| 24. FUNERAL DIRECTOR<br>Name<br><b>J. J. Hartenstein, New Freedom, PA</b><br>17349   |   |   |  |   |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 4 3 0 2 2 8

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |  |  |  |  |
|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Smith Royster Jr.</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 12 84</b> |   |  | 2b. HOUR<br><b>M</b>   |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 5 28</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>56</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N. C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City Md.</b>   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>817 Gilrubin Ct.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Balto.</b>   |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>817 Gilrubin Ct. 21212</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Smith Royster Sr.</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Georgia Royster</b>   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>578-30-5702</b>   |  | 17. INFORMANT ADDRESS<br><b>Georgia Royster 817 Gilrubin Ct.</b>  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic Artery Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Several years</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Several years</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/17/80</b> , 19____, to <b>5/31/84</b> , 19____, that (I) (we) lost saw the deceased alive on <b>5/31/84</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.                   |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Hollis</b>  |  | DEGREE<br><b>DEANARINE, MD</b>   |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/14/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Hollis</b>   |  | 22e. ADDRESS<br><b>2010 York Road, Balt., Md 21212</b>   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11-16-84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt Auburn Cem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H 1101 E. North Ave.</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 15 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Jana Davidson-Randall</b>   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1. STATE  
REGISTRAR

|   |   |   |  |   |   |
|---|---|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Ethel M. Rudolph</b> |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11.5.84</b>                                |   | 2b. HOUR<br><b>1058AM</b>                                       |
| 3. SEX<br><b>F</b>  | 4. RACE<br><b>B</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 31 12</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Ala.</b>                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US A</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>City</b> MD.   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                       | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Simon Hosp of Baltimore</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>housewife</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>—</b>                   |
| 13a. STATE<br><b>Md</b>   |   | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Arthur</b>                             |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Lewis</b>  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>3225 Spaulding Ave / 21215</b>                             |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>418149632</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Hudson Coles 3225 Spaulding Ave.</b>                             |   |

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **cardiopulmonary arrest**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **breast cancer c & G, bone, pleural met**

DUE TO, OR AS A CONSEQUENCE OF

(c) **abd obstruction**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10.26</b> , 19 <b>84</b> , to <b>11.5</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>11.5</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Vicki Raab MD</b>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED<br><b>11.5.84</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>VICKI RAAB</b>  |  |  |  | 22e. ADDRESS<br><b>Simon Hosp of Baltimore</b>   |  |

|  |                             |  |   |
|--|-----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                      | 23b. DATE<br><b>11/9/84</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn Cem.</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD</b> |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Ave.</b> |                             | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 7 1984</b>           | 25b. REGISTRAR'S SIGNATURE<br><b>Via Davidson-Randall</b>         |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 30230

1- FOR  
STATE  
REGISTRAR

|   |  |  |   |  |  |   |  |  |   |  |  |   |  |  |  |  |  |                            |  |  |          |  |  |
|---|--|--|---|--|--|---|--|--|---|--|--|---|--|--|--|--|--|----------------------------|--|--|----------|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST Andrew  |  |  | MIDDLE O.   |  |  | LAST Russ   |  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR |  |  | 2b. HOUR                                     |  |  |                            |  |  |          |  |  |
| 3 SEX   |  |  | 4 RACE  |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR  |  |  | 6 AGE (IN YEARS)<br>(LAST BIRTHDAY)                                 |  |  | IF UNDER 1 YR.  |  |  | IF UNDER 24 HRS.                             |  |  | 7c. DATE PRONOUNCED DEAD   |  |  | 7d. HOUR |  |  |
| Male  |  |  | Black   |  |  | 12-2-1913   |  |  | 70 YRS.   |  |  |   |  |  |  |  |  | 11/13/84                   |  |  | 1:45     |  |  |
| 7a. PLACE OF BIRTH  |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |  |  |   |  |  |  |  |  |                            |  |  |          |  |  |
| Phila. Pa.  |  |  | USA   |  |  | Baltimore City,   |  |  |   |  |  |   |  |  |  |  |  |                            |  |  |          |  |  |
| 10 CITY OR TOWN OF DEATH  |  |  | 11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 17a. USUAL OCCUPATION (TYPE OF WORK)  |  |  | 17b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |   |  |  |  |  |  |                            |  |  |          |  |  |
| Baltimore   |  |  | 3515 Hayward Street   |  |  | Porter  |  |  | Race-track  |  |  |   |  |  |  |  |  |                            |  |  |          |  |  |
| 12a. STATE  |  |  | 12b. COUNTY   |  |  | 12c. CITY OR TOWN   |  |  | 13d. INSIDE CITY LIMITS?  |  |  | 13e. STREET ADDRESS   |  |  |  |  |  |                            |  |  |          |  |  |
| Md  |  |  | —   |  |  | Balto.  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 3515 Hayward Ave  |  |  | Balto. Md 21215                              |  |  |                            |  |  |          |  |  |
| 14 FATHER'S NAME<br>FIRST   |  |  | MIDDLE  |  |  | LAST  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST                                   |  |  | MIDDLE  |  |  | LAST   |  |  |                            |  |  |          |  |  |
| Unknown   |  |  |   |  |  |   |  |  | Unknown   |  |  |   |  |  |  |  |  |                            |  |  |          |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |  |  | 16b. SOCIAL SECURITY NO.  |  |  | 17 INFORMANT  |  |  | ADDRESS   |  |  |   |  |  |  |  |  |                            |  |  |          |  |  |
| No  |  |  | 214-09-8568   |  |  | Clifton L. Russ   |  |  | Phila. Pa. 19104<br>1729 N. 42nd ST                                 |  |  |   |  |  |  |  |  |                            |  |  |          |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:   |  |  |   |  |  |   |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |                            |  |  |          |  |  |
| IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease   |  |  |   |  |  |   |  |  |   |  |  |   |  |  |  |  |  |                            |  |  |          |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |  |  |   |  |  |   |  |  |   |  |  |  |  |  |                            |  |  |          |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:   |  |  |   |  |  |   |  |  |   |  |  |   |  |  |  |  |  |                            |  |  |          |  |  |
| (b)   |  |  |   |  |  |   |  |  |   |  |  |   |  |  |  |  |  |                            |  |  |          |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |  |  |   |  |  |   |  |  |   |  |  |  |  |  |                            |  |  |          |  |  |
| (c)   |  |  |   |  |  |   |  |  |   |  |  |   |  |  |  |  |  |                            |  |  |          |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |  |   |  |  |   |  |  |   |  |  |   |  |  |  |  |  |                            |  |  |          |  |  |
| Chronic Obstructive Pulmonary Disease & Chronic Alcoholism  |  |  |   |  |  |   |  |  |   |  |  |   |  |  |  |  |  |                            |  |  |          |  |  |
| 19a. DATE OF OPERATION  |  |  |   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |   |  |  | 20 AUTOPSY?   |  |  |  |  |  |                            |  |  |          |  |  |
|   |  |  |   |  |  |   |  |  |   |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |  |  |  |  |  |                            |  |  |          |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)           |  |  |  |  |  |                            |  |  |          |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |  |   |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                       |  |  |  |  |  |                            |  |  |          |  |  |
|   |  |  |   |  |  |   |  |  |   |  |  |   |  |  |  |  |  |                            |  |  |          |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |  |   |  |  |   |  |  |   |  |  |   |  |  |  |  |  |                            |  |  |          |  |  |
| ACTUAL SIGNATURE  |  |  |   |  |  | TITLE (SPECIFY)<br>M.D. Assistant   |  |  |   |  |  | DATE SIGNED 11/13/84  |  |  |  |  |  |                            |  |  |          |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)  |  |  |   |  |  | Gregory R. Kauffman, M.D.   |  |  |   |  |  | ADDRESS 111 Penn St.  |  |  |  |  |  |                            |  |  |          |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |  |   |  |  | 23b. DATE   |  |  |   |  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |  |  |  |  | 23d. LOCATION              |  |  |          |  |  |
| Cremation   |  |  |   |  |  | 11/16/84  |  |  |   |  |  | Westview  |  |  |  |  |  | Catonville Balto. Md       |  |  |          |  |  |
| 24 FUNERAL DIRECTOR<br>NAME   |  |  |   |  |  | ADDRESS   |  |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR   |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE |  |  |          |  |  |
| Russell B. Oden   |  |  |   |  |  | Balto. Md 21217<br>1631 Druid Hill Ave  |  |  |   |  |  | NOV 16 1984   |  |  |  |  |  |                            |  |  |          |  |  |

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

